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Supreme Court, U.S.

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No. 89-

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioner,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

**PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT**

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QUESTIONS PRESENTED

1. Whether a jury is precluded as a matter of law from finding that a monopolist violated section 2 of the Sherman Act by reducing its payments to any supplier who persisted in marketing through an emerging competitor, when the effect of that conduct was to raise the costs and threaten the survival of the competitor and thus to raise the prices paid by consumers?
2. Whether the McCarran-Ferguson exemption for acts of coercion is to be narrowly construed to permit a monopolist to utilize a discriminatory pricing scheme to force customers to refrain from dealing with competitors?
3. Whether the McCarran-Ferguson Act should protect actions by an insurer which are initiated without the requisite state regulatory approval and, in any event, are not actively supervised by the state?
4. Whether a federal court may apply Sherman Act standards for exclusionary conduct in overturning a jury verdict based on the state tort of interference with contractual relationships?

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
STATUTES INVOLVED	1
STATEMENT OF THE CASE	2
SUMMARY	10
REASONS FOR GRANTING THE PETITION	14
I. THE COURT OF APPEALS' DECISION CREATES A SPECIAL RULE OF PER SE LEGALITY FOR NON-PRICE PREDATION IN DEROGATION OF APPROPRIATE SECTION 2 JURISPRUDENCE	14
A. The Court of Appeals Erred in Applying to Non-price Predation Concepts Borrowed from the Law of Predatory Pricing	14
B. A Merely Colorable Business Justification for Conduct Alleged to be Exclusionary has Never Been Deemed a Sufficient Defense for Non-price Predation Under Section 2	16
C. The Court of Appeals Failed to Recognize as a Factual Matter, and thus Immunized as a Matter of Law, a Classic Instance of Non-price Predation, by which a Monopolist Raised its Rivals' Costs, Entrenched its Position as the Dominant Marketer of Physician Services, and Raised the Cost of Health Care and Health Insurance	17

TABLE OF CONTENTS—Continued

	Page
II. THE DECISION BELOW EXTENDS THE REACH OF THE McCARRAN-FERGUSON EXEMPTION TOO BROADLY	22
A. The McCarran-Ferguson Act Should Not Be Interpreted to Preclude Consideration of Exempt Conduct That Is Intertwined With Non-Exempt Conduct	22
B. The Decision Below Reflects the Lack of Standards for Applying the “Coercion” Exception to the McCarran-Ferguson Act.....	24
C. This Court Should Reconsider the Extent to Which Passive State Regulation Is Sufficient to Invoke the McCarran-Ferguson Exemption	25
III. THIS COURT SHOULD GIVE EFFECT TO THE INDEPENDENT OBJECTIVES OF STATE TORT LAW	29
CONCLUSION	30

TABLE OF AUTHORITIES

Cases	Page
<i>A. A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.</i> , 881 F.2d 1396 (7th Cir. 1989)	12
<i>Allstate Insurance Co. v. Lanier</i> , 361 F.2d 870 (4th Cir. 1966)	27
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	11, 13, 17, 22
<i>Associated Gen. Contractors of Cal. v. California State Council of Carpenters</i> , 459 U.S. 519 (1983)	25
<i>Ball Memorial Hosp. v. Mutual Hosp. Ins. Co.</i> , 784 F.2d 1325 (7th Cir. 1986)	19
<i>Berkey Photo, Inc. v. Eastman Kodak Co.</i> , 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980)	16
<i>Blue Cross & Blue Shield of R.I. v. Cannon</i> , 589 F. Supp. 1483 (D.R.I. 1984)	3
<i>Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.</i> , 441 U.S. 1 (1979)	11
<i>Byars v. Bluff City News Co.</i> , 609 F.2d 843 (6th Cir. 1979)	12
<i>California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.</i> , 445 U.S. 97 (1980)	27
<i>Cargill, Inc. v. Monfort of Colorado, Inc.</i> , 479 U.S. 104 (1986)	11, 12, 15
<i>Cleveland v. Cleveland Elec. Illuminating Co.</i> , 734 F.2d 1157 (6th Cir.), cert. denied, 469 U.S. 834 (1984)	14
<i>Continental Ore Co. v. Union Carbide & Carbon Corp.</i> , 370 U.S. 690 (1962)	22
<i>FTC v. National Casualty Co.</i> , 357 U.S. 560 (1958)	26
<i>Ford Motor Co. v. United States</i> , 335 U.S. 303 (1948)	24
<i>Greyhound Computer Corp. v. IBM Corp.</i> , 559 F.2d 488 (9th Cir. 1977), cert. denied, 434 U.S. 1040 (1978)	16
<i>Group Life & Health Ins. Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979)	23, 24

TABLE OF AUTHORITIES—Continued

	Page
<i>In re Aviation Ins. Indus.</i> , 183 F. Supp. 374 (S.D.N.Y. 1960)	27
<i>In re E.I. DuPont de Nemours & Co.</i> , [1979-83 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,770 (1980)	16
<i>Kartell v. Blue Shield of Massachusetts</i> , 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985)	10, 19
<i>Lawyers Title Co. v. St. Paul Title Ins. Corp.</i> , 526 F.2d 795 (8th Cir. 1975)	26
<i>Lorain Journal Co. v. United States</i> , 342 U.S. 143 (1951)	17
<i>Matsushita Elec. Indus. Co. v. Zenith Radio Corp.</i> , 475 U.S. 574 (1986)	15
<i>MCI Communications Corp. v. American Tel. & Tel. Co.</i> , 708 F.2d 1081 (7th Cir.), cert. denied, 464 U.S. 891 (1983)	12
<i>McIlhenny v. American Title Ins. Co.</i> , 418 F. Supp. 364 (E.D. Pa. 1976)	26
<i>NCAA v. Board of Regents</i> , 468 U.S. 85 (1984)	11
<i>Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.</i> , 472 U.S. 284 (1985)	11
<i>Otter Tail Power Corp. v. United States</i> , 410 U.S. 366 (1973)	11
<i>Paschall v. Kansas City Star Co.</i> , 727 F.2d 692 (8th Cir.), cert. denied, 469 U.S. 872 (1984)	12
<i>Patrick v. Burget</i> , 486 U.S. 94, 108 S. Ct. 1658 (1988)	27
<i>Prudential Ins. Co. v. Benjamin</i> , 328 U.S. 408 (1946)	23
<i>Reazin v. Blue Cross and Blue Shield of Kansas, Inc.</i> , 663 F. Supp. 1360 (D. Kan. 1987)	13, 18
<i>SEC v. National Secs. Inc.</i> , 393 U.S. 453 (1969)	23
<i>Smith Dev. Corp. v. Bilow Enters., Inc.</i> , 112 R.I. 203, 308 A.2d 477 (R.I. 1973)	29
<i>St. Paul Fire & Marine Ins. Co. v. Barry</i> , 438 U.S. 531 (1978)	24

TABLE OF AUTHORITIES—Continued

	Page
<i>State of Ohio v. Ohio Med. Indem., Inc.</i> , 1976-2	
Trade Cas. (CCH) ¶ 61,128 (S.D. Ohio 1976)	27
<i>Telex Corp. v. IBM</i> , 510 F.2d 894 (10th Cir.),	
cert. dism'd, 423 U.S. 802 (1975)	16
<i>Trace X Chemical, Inc. v. Canadian Industries,</i>	
Ltd. C.I.L., 738 F.2d 261 (8th Cir. 1984), cert.	
denied, 469 U.S. 1160 (1985)	12
<i>Transamerica Computer Co. v. IBM Corp.</i> , 481	
F. Supp. 965 (N.D. Cal. 1979)	16
<i>Travelers Ins. Co. v. Blue Cross of Western Pa.</i> ,	
481 F.2d 80 (3d Cir.), cert. denied, 414 U.S.	
1093 (1973)	21
<i>Union Labor Life Ins. Co. v. Pireno</i> , 458 U.S. 119	
(1982)	28
<i>United States Navigation Co. v. Cunard S.S. Co.</i> ,	
284 U.S. 474 (1932)	25
<i>United States v. E.I. DuPont de Nemours & Co.</i> ,	
351 U.S. 377 (1956)	14
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563	
(1966)	11, 13, 14
<i>United States v. Patten</i> , 226 U.S. 525 (1913)	22
<i>United States v. Sylvanus</i> , 192 F.2d 96 (7th Cir.	
1951), cert. denied, 342 U.S. 943 (1952)	26
<i>Washburn v. Brown</i> , 1986 WL 7062 (N.D. Ill.	
1986)	26
 <i>Statutes</i>	
28 U.S.C. § 1254(1)	1
28 U.S.C. § 1331	8
 <i>Clayton Act</i>	
Section 16, 15 U.S.C. § 26	8
 <i>McCarran-Ferguson Act</i>	
Section 2, 15 U.S.C. § 1012	<i>passim</i>
Section 3, 15 U.S.C. § 1013	2, 24
 <i>Sherman Act</i>	
Section 2, 15 U.S.C. § 2	<i>passim</i>
Section 15, 15 U.S.C. § 15	8

TABLE OF AUTHORITIES—Continued

<i>Miscellaneous</i>	<i>Page</i>
Baker, <i>Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs</i> , 14 Am. J. L. & Med. 147 (1988)	13, 18
Havighurst, <i>The Questionable Cost-Containment Record of Commercial Health Insurers</i> , in <i>Health Care in America</i> , 221 (H. Frech, ed. 1988)	19, 21
Krattenmaker and Salop, <i>Analyzing Anticompetitive Exclusion</i> , 56 Antitrust L.J. 71 (1987) ...	12, 15, 20
Krattenmaker and Salop, <i>Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price</i> , 96 Yale L.J. 209 (1986)	12
Levit, Freedland, and Waldo, <i>Health Spending and Ability to Pay: Business, Individuals and Government</i> , 10 Health Care Financing Rev. 1 (Spring 1989)	18
McCarthy, <i>Trademarks and Unfair Competition § 1:14</i>	29
Miller, <i>Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?</i> , 51 L. & Contemp. Probs. 195 (1988)	13, 15, 17, 18, 20
Restatement (Second) of Torts § 767, comment d..	29
Stenger, <i>Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?</i> , 15 Am. J. L. & Med. 111 (1989)	13

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**PETITION FOR A WRIT OF CERTIORARI TO THE
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OPINIONS BELOW

The opinion of the Court of Appeals is reported at 883 F.2d 1101 and is reprinted in the Appendix hereto. The opinion of the district court granting judgment n.o.v. in favor of respondent is reported at 692 F. Supp. 52, and also is reprinted in the Appendix.

JURISDICTION

The judgment of the court of appeals was entered on August 21, 1989. A timely Motion for Rehearing With Suggestion for Rehearing *En Banc* was denied on September 25, 1989, and this petition for Writ of Certiorari was timely filed. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

Section 2 of the Sherman Act, 15 U.S.C. § 2, provides in pertinent part:

Every person who shall monopolize, or attempt to monopolize . . . any part of the trade or commerce among the several States, . . . shall be deemed guilty of a felony. . .

Section 2 of the McCarran-Ferguson Act, 15 U.S.C. § 1012, provides in pertinent part:

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance. . . . *Provided*, that after June 30, 1948, . . . the Sherman Act, and . . . the Clayton Act . . . shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

Section 3 of the McCarran-Ferguson Act 15 U.S.C. § 1013, provides in pertinent part:

Nothing contained in this chapter shall render the said Sherman Act inapplicable to any . . . act of boycott, coercion, or intimidation.

STATEMENT

1. Petitioner Ocean State Physicians Health Plan ("Ocean State") is a federally-qualified health maintenance organization ("HMO") licensed by the State of Rhode Island. (J.A. 7.)¹ Since 1983, Ocean State has offered health benefits on a prepayment basis to employer groups throughout the State. (J.A. 11, 60.) At the outset of the time period at issue in this case, Ocean State provided physician services to enrolled employees through contracts with approximately 1,200 physicians.² (J.A. 52.)

2. Respondent, Blue Cross and Blue Shield of Rhode Island ("Blue Cross") was created in 1982 by the merger of the then-separate Blue Cross and Blue Shield plans in Rhode Island. (J.A. 28.) Blue Cross is the dominant health insurer in Rhode Island, with a market

¹ References in the Statement are to the Joint Appendix ("J.A.") and Plaintiffs' Exhibits ("P.E.") in the record on appeal.

² Ocean State Physicians Health Plan is a stock corporation, of which 80 percent of the shares are owned by Ocean State Coordinated Health Services Corporation. The remaining 20 percent of the shares are owned by United Healthcare, Inc. Petitioners Anthony J. Kazlauskas and Jeffrey C. Winters are members of a court-certified class of physicians who, during the time period at issue in this case, provided services to Ocean State and who also received reimbursement for their services from respondent, Blue Cross and Blue Shield of Rhode Island. (J.A. 2-3, 273; P.E. 425.)

share of at least 80%. (J.A. 266-68; P.E. 48-49, 56, 59.) Indeed, it is conceded in this case that Blue Cross has monopoly power. *See* 883 F.2d at 1110; 692 F. Supp. at 58. Blue Cross also is the largest marketer of physicians' services in Rhode Island, having participation contracts with nearly 2,000 physicians—more than 90% of those in the State. (J.A. 52, 318-20.) Blue Cross markets its health insurance to consumers and employers by emphasizing its broad panel of participating physicians. (P.E. 48, 49.)

3. This litigation arose from Petitioners' claims that, during 1986, Blue Cross engaged in an anticompetitive pattern of conduct intentionally designed both to raise Ocean State's costs by threatening its broad-based panel of contracting physicians, and to economically coerce employers to refrain from offering Ocean State as an alternative to Blue Cross. Those actions were asserted to violate Sections 1 and 2 of the Sherman Act, and the antitrust laws of the state of Rhode Island, as well as the state tort law prohibition against interference with contractual relationships, *i.e.*, between Ocean State and the members of the physician class. 692 F. Supp. at 54-55.

4. Typically, employers offered enrollment in Ocean State to each of their employees as an alternative to Blue Cross. *Blue Cross & Blue Shield of R.I. v. Cannon*, 589 F. Supp. 1483 (D.R.I. 1984). Following its entry into the market in 1984, Ocean State was able to grow from 12,000 members in December, 1984, to 87,000 members by the end of 1986, a 10% market share. (J.A. 78, 85-86, 89.) Approximately 75,000 of Ocean State members were former Blue Cross subscribers. (J.A. 57.) Indeed, since Ocean State's inception, Blue Cross regarded Ocean State as a special competitor because of its strong level of physician participation and support. (P.E. 65) Ocean State's success was, in fact, due in large measure to its 1,200 participating physicians, as well as its adoption of various cost containment strategies, including a program of utilization review and physician incentives. (J.A. 763,

806-07, 2167-69; P.E. 45.) Under Ocean State's program of physician incentives, 20% of each physician's fees were "withheld" contingent on Ocean State's overall profitability. As a result of its innovative arrangements, Ocean State was able to offer a benefit package to consumers that was 15% broader than the Blue Cross package, at a price that was 5%-7% lower. (P.E. 45.)

5. Initially, Blue Cross attempted to respond to Ocean State's competitive challenge by keeping its premiums at bare-bones levels (J.A. 1249-50; P.E. 338), but this strategy was unsuccessful. During 1985, Blue Cross lost approximately \$12.3 million on its group insurance business. (J.A. 1109.) During the first half of 1986, Blue Cross lost another \$14 million on its group business, as well as a substantial number of subscribers. (J.A. 1110, 2017.) Facing the need for a substantial increase in premiums, which it feared would merely exacerbate the already clear trend toward enrollment in Ocean State, Blue Cross was forced either to improve the attractiveness of its own product or to attack Ocean State. It chose the latter course. Blue Cross' "formalized plan of attack" (J.A. 48; P.E. 416), against Ocean State ultimately included three distinct but related courses of conduct. (J.A. 334-35; P.E. 35, 638.)

a) *Adverse Selection Pricing.* Blue Cross undertook, without state approval (J.A. 1140.), a system of differential pricing under which employers offering competing health plans (including, in particular, Ocean State) were taxed with certain "adverse selection" factors, as a result of which those employers paid higher premiums than employers which offered only Blue Cross coverage to their employees. (J.A. 61-62, 518-25.) Those higher premiums in fact were arbitrarily derived and were not the product of legitimate actuarial determinations.³ (J.A. 540-45, 1003-07, 1015-20, 1153-54; P.E. 343.)

³ The State ordered Blue Cross to cease using its Adverse Selection pricing until it obtained State approval for the rating formula. 692 F. Supp. at 59. Even after the State approved the formula,

b) *HealthMate.* Simultaneously, Blue Cross introduced an HMO "fighting ship" product called HealthMate. This product, which mimicked the Ocean State benefit package (J.A. 716-17; P.E. 293), was offered *only* to employers who also offered, or were known to be considering, the Ocean State plan,⁴ and only as an alternative to traditional Blue Cross coverage, *i.e.*, rather than as a stand alone product.⁵ (J.A. 59-60, 539-40, 831, 1091.) Blue Cross did not investigate the market attractiveness of HealthMate and did not consider HealthMate to be financially viable in the long term. (J.A. 719; P.E. 77.) Indeed, one Blue Cross executive recognized that if the plan was successful in attracting subscribers it would be an economic "disaster." (P.E. 353.) The more people that chose to participate in the program, the more money Blue Cross expected to lose. (J.A. 752-53, 1094.) The purpose of the product was to "save groups and increase enrollment." (P.E. 77.)

c) *Prudent Buyer.* Blue Cross also announced a policy under which it would not pay more for any physician's services than the physician was accepting from any competitor of Blue Cross. (P.E. 41, 113, 294.) Despite its facial neutrality, the policy was intended to penalize physicians who continued to contract with Ocean State

Blue Cross was able to manipulate the resulting rates by overestimating the number and health status of its enrollees who would be lost to Ocean State. (J.A. 1137.) As a result, employers who offered Ocean State paid artificially high premium differentials. (J.A. 65-66, 553-59, 1104.)

⁴ Thus, HealthMate was never offered to Blue Cross' own employees. (J.A. 1990.)

⁵ Under Blue Cross' differential pricing scheme, employers who offered both HealthMate and Ocean State as an alternative to traditional Blue Cross coverage were quoted lower rates than those who offered only Ocean State as an alternative—but not as low as the rates they would receive if they offered only traditional Blue Cross. (J.A. 61-62, 587-88.)

by reducing payments to those physicians by 20%.⁶ (J.A. 845-46.) As one Blue Cross executive wrote in an internal memorandum, "not one guy in the state isn't going to know the implication of signing with Ocean State." (P.E. 38.) Physicians who did not contract with Ocean State, or who dropped their Ocean State contracts, were paid their full Blue Cross rates.

During the initial phase of Prudent Buyer, physicians who did not pledge, by September 15, 1986, that Blue Cross payment amounts were the lowest they would accept were subjected to a 20% reduction in their Blue Cross payment rates. (J.A. 29, 840, 1238-39.) The 20% figure was chosen because, at that time, it represented the amount Ocean State withheld from its participating physicians as a cost containment incentive (J.A. 29.) That amount, however, did not necessarily represent a discount because Ocean State could, and sometimes did, return all or part of the "withhold" amount depending on the year's profitability. (J.A. 227, 783-84, 874-48.)

In order to give Ocean State physicians time to resign from Ocean State, Blue Cross changed the implementation date of the Prudent Buyer policy and undertook an effort to inform physicians of the Ocean State contract termination date. (P.E. 45, 294, 344; J.A. 852-55, 1220-22, 1227-31.)⁷ Moreover, Blue Cross even "grandfathered" some physicians who missed the Ocean State contractual cut-off date if those physicians pledged that they would drop out of Ocean State the following year. (J.A. 1208-09.)

In the second phase of Prudent Buyer, Blue Cross abandoned any pretense of seeking only "most favored"

⁶ In fact, the 20% payment reduction was applied only to Ocean State physicians. (J.A. 779, 845-46.) Blue Cross made no effort to determine whether any insurer other than Ocean State obtained any discount from physicians. (J.A. 780.)

⁷ Failure to notify Ocean State of termination 90 days before the termination date required the physicians to continue their Ocean State contracts for an additional year. (J.A. 854, 861, 1208-19.)

rates and simply reduced the fee profile of those physicians who continued to contract with Ocean State by 20%, without regard to the actual amount paid by Ocean State. (J.A. 225-29, 780-84.)

Cost-savings were not the motivation for Prudent Buyer, as Blue Cross' witnesses conceded at trial. (J.A. 850.) Blue Cross made no initial estimates of any savings that were to be achieved (J.A. 336-37, 850-51) and actual savings proved to be extremely small, approximately one-half of one percent of Blue Cross' total private health insurance payments. (J.A. 1232; P.E. 640.) What Blue Cross *did* estimate was the cost advantage enjoyed by Ocean State by virtue of its physician "withhold" arrangement—i.e., \$1.4 million. (J.A. 336-39; P.E. 45.) When asked to explain why Blue Cross estimated Ocean State's savings rather than their own, Blue Cross' Chairman of the Board of Directors offered no answer. (J.A. 339.) Yet, Blue Cross' own documents clearly indicate the reason: Blue Cross didn't have the luxury of waiting another year for Ocean State's physicians to resign. (P.E. 45.)

6. Following the 1986 implementation of Blue Cross' tripartite strategy, Ocean State experienced the defection of approximately one-third of its physicians. (J.A. 52, 158, 636-37.) Concomitantly, Ocean State incurred approximately \$2 million in additional costs to replace the services of the defecting physicians and to strengthen its marketing. (J.A. 154-55, 168-69, 181-82, 255-56, 1443.) Ocean State's enrollment ceased to grow and it lost the business of some employers. (J.A. 65, 163-66, 585-89, 1256-57, 1268, 1426-28; P.E. 739-741, 771-772, 775.)

7. As Ocean State's induced reverses were realized, Blue Cross' financial situation improved markedly. During the six-month period beginning in September 1986, Blue Cross recorded nearly \$10 million in surplus. (J.A. 1111.) That turnaround resulted largely from the imposition of profitable increases in premium levels, as Blue Cross' experts conceded at trial. (J.A. 1110-13, 1847-49, 2183-84.)

8. This litigation was commenced by Ocean State on Sept. 30, 1986, alleging that Blue Cross' conduct constituted a violation of Sections 1 and 2 of the Sherman Act, as well as state antitrust laws and the state common law prohibition on tortious interference with contractual relationships. The jurisdiction of the district court was invoked under 15 U.S.C. § 15 and 28 U.S.C. § 1331.

9. At the close of the petitioners' case, the district court granted Blue Cross' motion for a directed verdict as to the Section 1 claim. (J.A. 1550.) The Sherman Act Section 2 claim and the tort claim were submitted to the jury, which returned a verdict finding the defendant, Blue Cross, "guilty" on both the Section 2 and tortious interference claims. After twice returning an award of damages undifferentiated as to the separate claims, the jury was instructed by the district court that damages could be awarded only once. The jury then maintained its liability finding on both claims, but attributed the monetary damages to the tort claim.*

10. Petitioners thereupon sought entry of an injunction pursuant to Section 16 of the Clayton Act, 15 U.S.C. § 26, and requested additur on the antitrust claim, while Blue Cross moved for judgment notwithstanding the verdict on both claims and, alternatively, for a new trial on the tort claim alone. By opinion and order dated July 27, 1988, and July 28, 1988, respectively, the district court granted the motion of Blue Cross for j.n.o.v. and denied petitioner's motions. The district court conceded that Blue Cross "clearly had market power." 692 F. Supp. at 58. However, the court held that Ocean State and the physician class had failed to establish causation by virtue of the jury's failure to award damages on the Section 2 claim. The court additionally held that, in any

* On the tortious interference count, the jury awarded Ocean State \$947,000 in compensatory and \$250,000 in punitive damages, and awarded the physician class compensatory damages of \$1,746,437. (J.A. 31-32; 692 F. Supp. at 55-56.)

event, Blue Cross' Adverse Selection, HealthMate, and Prudent Buyer strategies did not violate Section 2, notwithstanding the jury verdict, because each element of Blue Cross strategy could be explained as "justified responses to competitive conditions." 692 F. Supp. at 73. In so doing, the district court determined that the existence of market power does not prohibit a monopolist from undertaking conduct that could lawfully be undertaken by a firm without market power. 692 F. Supp. at 71.

11. Finally, the court held that Blue Cross' conduct did not constitute tortious interference with Ocean State's physician contracts because it deemed the physician defection from Ocean State to be the result of the individual decisions of the participating physicians and, in any event, it deemed Blue Cross' actions to be legitimate under the same analysis used with respect to the Sherman Act claim.

12. The court of appeals affirmed on somewhat different grounds. Specifically, the court of appeals declined to adopt the district court's view that the jury's failure to award damages precluded a finding of antitrust liability, noting *inter alia* the jury's apparent difficulty in allocating damages between the antitrust and tort claims, as well as the lack of clarity in the district court's instructions on this point. 883 F.2d at 1106-07 n.5. The court then determined that Petitioners' Section 2 challenge, insofar as it related to the HealthMate and Adverse Selection policies, was barred by the McCarran-Ferguson Act, notwithstanding the fact that Blue Cross did not raise the McCarran defense with regard to HealthMate. 883 F.2d at 1107 n.6. Although noting that Rhode Island's regulation of those activities lacked specificity, the court held that specific supervision was not required and the existence of a general regulatory scheme was sufficient to invoke the McCarran-Ferguson exemption. 883 F.2d at 1108-09. The court also summarily determined that Blue Cross' use of Adverse Selection to force employers to drop Ocean State did not constitute "coercion" within the

meaning of the exception to the McCarran-Ferguson exemption. 883 F.2d at 1109.

13. Recognizing that Prudent Buyer did not qualify for McCarran-Ferguson protection as the "business of insurance," the circuit court conceded that the trial court erred in failing to recognize that the same conduct which might be harmless when undertaken by an actor without market power can be unlawful when undertaken by a monopolist, such as Blue Cross. 883 F.2d at 1110. The court also conceded that a jury could have found that Blue Cross' conduct was designed to eliminate Ocean State as a competitor. 883 F.2d at 1113. Nonetheless, the court ruled, as a matter of law, that the Prudent Buyer policy was not exclusionary. Relying on *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985), the court held that, notwithstanding the jury verdict, Prudent Buyer must be characterized as a purchaser's effort to obtain the best possible price. 883 F.2d at 1112-13. The court stated that "a policy in insisting on a supplier's lowest price—assuming that the price is not 'predatory' or below the supplier's incremental cost—tends to further competition and, as a matter of law, is not exclusionary." 883 F.2d at 1110 (emphasis added).

14. The Court of Appeals also held that Prudent Buyer did not constitute tortious interference with Ocean State's physician contracts "for essentially the same reasons" that it deemed the conduct not violative of the Sherman Act, *i.e.*, that it constituted "legitimate competitive activity." 883 F.2d at 1114.

SUMMARY

This case presents an opportunity for this Court to correct legal errors of potentially far-reaching consequence for the administration of Section 2 of the Sherman Act. The Court of Appeals below enunciated a rule of *per se* legality that, if generally adopted, would shield all exclusionary practices for which a defendant monopolist could proffer any colorable efficiency justification.

Disregarding the jury's verdict that Blue Cross was "guilty" of monopolization the First Circuit held that the conduct at issue was not exclusionary as a matter of law, even though respondent's monopoly power was not questioned; the court acknowledged that respondent may have intended to use its monopoly power to destroy its only effective competitor; and the jury legitimately could have found that respondent exercised that power to the detriment of consumers. It would be difficult to imagine a holding more directly at odds with, and posing a greater threat to, appropriate standards of liability under Section 2 of the Sherman Act.

In the 23 years since the decision in *United States v. Grinnell Corp.*, 384 U.S. 563 (1966), this court has reviewed only two Section 2 cases: *Otter Tail Power Corp. v. United States*, 410 U.S. 366 (1973), and, *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985). Moreover, only *Aspen Skiing* has been decided since this Court began to enunciate an approach to antitrust jurisprudence which inquires more closely into the existence of economic efficiency and harm to consumers.⁹

The court of appeals misconstrued *Aspen Skiing* in two ways. First, it read this Court's holding to require the question of liability to be determined as a matter of law, rather than on the factual record as a whole. It then adopted a rationality test of monopoly conduct, under which conduct explainable as furthering an efficiency interest cannot be exclusionary, regardless of the actual purpose of the conduct, or its potential for harm to consumers.

The protectiveness manifested by the court of appeals towards the monopolist in this case may be understood as a misguided attempt to employ this Court's modern

⁹ This focus is evident in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979); *NCAA v. Board of Regents*, 468 U.S. 85 (1984); *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985); and *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104 (1986).

approach to antitrust analysis. Yet, the opinion below clearly tips the balance too far in favor of any proffered efficiency justification, at the expense of the jury's inquiry into the actual nature and effect of the conduct at issue.

The court of appeals also misappropriated principles used in "predatory pricing" analysis.¹⁰ 883 F.2d at 1110. Strategic behavior by a monopolist—increasingly referred to as "non-price predation"—is different in character from "predatory pricing." Krattenmaker and Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209, 224 (1986). Strategies like that employed by Blue Cross in this case are clearly more plausible, less expensive to initiate, and potentially successful even if the competitor does not exit the market. Krattenmaker and Salop, *Analyzing Anticompetitive Exclusion*, 56 Antitrust L.J. 71 (1987). Compare *Cargill*, 479 U.S. at 119 n.15, 121 n.17.

The decision below thus illustrates what has been described as the "substantial disarray" in antitrust law governing exclusionary conduct, reflecting a conflict between prevailing doctrine and "pleas for laissez-faire rules" of *per se* legality.¹¹ Krattenmaker and Salop, *Ana-*

¹⁰ Even with respect to "predatory pricing," there is a significant split in the circuits regarding the appropriate standard for "exclusionary" conduct. See *Cargill*, 479 U.S. at 117 n.12; *A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.*, 881 F.2d 1396 (7th Cir. 1989).

¹¹ For example, some courts have stated that unlawful monopolization can be established whenever a defendant with monopoly power specifically intends to monopolize, even in the absence of anti-competitive effects. *Paschall v. Kansas City Star Co.*, 727 F.2d 692, 696 (8th Cir.), cert. denied, 469 U.S. 872 (1984). See also *MCI Communications v. American Tel. & Tel. Co.*, 708 F.2d 1081, 1148 (7th Cir.), cert. denied, 464 U.S. 891 (1983). In contrast, some courts have stated "what should matter is not the monopolist's state of mind, but the overall impact of the monopolist's practice." *Byars v. Bluff City News Co.*, 609 F.2d 843, 860 (6th Cir. 1979). Indeed, the same circuit court has enunciated inconsistent standards. Compare *Paschall* with *Trace X Chemical, Inc. v. Canadian*

lyzing Anticompetitive Exclusion at 89-90. This "disarray" is particularly apparent with regard to the analysis of health insurers' exclusionary conduct. Compare *Ocean State with Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*, 663 F. Supp. 1360, 1418 (D. Kan. 1987) (appeal pending) (describing Blue Cross plan's "most favored nations" clause in provider contracts as furthering Blue Cross' ability to control insurance prices). The court of appeals' decision should be reversed, not only to encourage active competition in the economically significant health insurance and physician services markets, but, more importantly to reaffirm the basic principles of antitrust law embodied in *Grinnell* and *Aspen Skiing*, and to enunciate the appropriate legal standard for non-price predation involving conduct designed to raise rivals' costs. See Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs*, 14 Am. J. Law & Med. 147, 150-51, 161-62 (1988).¹²

This case also raises important legal questions concerning the appropriate scope of the McCarran-Ferguson exemption to the antitrust laws. Specifically, this case provides an opportunity for this Court, for the first time, to define "coercion" in the context of the statutory exception to the McCarran-Ferguson shield for the "business of insurance". Moreover, this case also provides an opportunity to address the breadth of the McCarran-Ferguson exemption itself, as it applies to insurer's conduct that is unsupervised by the states. Lower court decisions since the 1940's, including the decision below, have taken an increasingly broad view of the "regulated by state law" aspect of the exemption, which is plainly inconsistent with this Court's recent pronouncements that

Industries, Ltd. C.I.L., 738 F.2d 261, 268 (8th Cir. 1984), cert. denied, 469 U.S. 1160 (1985).

¹² See also Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemporary Problems 195 (1988); Stenger, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?*, 15 Am. J. Law & Med. 111 (1989).

the McCarran exemption should be narrowly construed. Finally, this case presents the opportunity for this Court, for the first time, to determine whether federal courts may apply Sherman Act standards in determining liability under state tort law.

REASONS FOR GRANTING THE PETITION

I. THE COURT OF APPEALS' DECISION CREATES A SPECIAL RULE OF PER SE LEGALITY FOR NON-PRICE PREDATION IN DEROGATION OF APPROPRIATE SECTION 2 JURISPRUDENCE

The jury's verdict in favor of Ocean State was rendered pursuant to instructions which reflect the settled and well-understood precepts of Section 2 liability: possession of monopoly power, the willful maintenance of that power through restrictive or exclusionary conduct, and injury to competition. *Grinnell*, 384 U.S. at 570-71.¹³

The court of appeals deprived Ocean State of its jury verdict on the theory that conceded monopoly power cannot have been exercised unlawfully if the defendant can offer any purported efficiency justification for its conduct. Far from ensuring that aggressive competition is protected from inappropriate condemnation as a restraint of trade, the First Circuit's special rule further insulates the exclusionary conduct of a monopolist—in this case, conduct designed to raise rivals' costs—from antitrust scrutiny.

A. The Court of Appeals Erred in Applying to Non-price Predation Concepts Borrowed from the Law of Predatory Pricing

In analyzing the merits of Blue Cross' Prudent Buyer program, the Court of Appeals inappropriately borrowed from the emerging law governing predatory pricing.

¹³ Monopoly power includes the power to exclude competition. *United States v. E.I. DuPont de Nemours & Co.*, 351 U.S. 377, 389, 391 (1956); *Cleveland v. Cleveland Elec. Illuminating Co.*, 734 F.2d 1157, 1168 (6th Cir.), *cert. denied*, 469 U.S. 884 (1984).

Although the alleged exclusionary practice did involve prices—specifically, a monopolist's use of price-setting power to induce its suppliers to deal exclusively with it—the scheme can be seen as a classic instance of “raising rivals' costs”, a form of non-price predation. This conduct bears only a very distant kinship to predatory pricing.

The court of appeals concluded that the lower reimbursement levels which Blue Cross imposed could not be exclusionary unless they were below the suppliers' incremental costs. 883 F.2d at 1110. Such a cost-based test may be helpful in predatory pricing cases as a way of distinguishing competitive pricing based on efficiency from conduct which involves accepting short-run losses in anticipation of their recoupment once the competitors are destroyed. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 584 n.8 (1986); *Cargill*, 479 U.S. at 117-18. In this case, however, the relationship between the suppliers' prices and their costs sheds little light on the buyer's purposes or the impact of its conduct on consumers. See Miller, *Vertical Restraints and Powerful Health Insurers* at 233-35.

This Court has noted that claims of predatory pricing are highly speculative or conjectural. *Matsushita*, 475 U.S. at 587-88. But exclusion by raising rivals' costs is a less conjectural strategy for a firm with market power. Cost-raising strategies do not require the sacrifice of short run profits, nor the competitor's exit from the market. The impact on the competitor's output is immediate and disproportionate. See Krattenmaker & Salop, *Analyzing Anticompetitive Exclusion* at 73. Thus, conclusive presumptions of legality are far more likely to shield exclusionary conduct in cases of non-price predation designed to raise rivals' costs.

B. A Merely Colorable Business Justification for Conduct Alleged to be Exclusionary has Never Been Deemed a Sufficient Defense for Non-price Predation Under Section 2

While the absence of any business justification for certain conduct is probative of an exclusionary purpose (and thus of the prohibited monopolistic effect), the mere proffer of an efficiency rationale has never been held by this Court to immunize a monopolist's conduct. Even behavior that might improve efficiency nonetheless may be deemed exclusionary if its benefits are only incidental in comparison to its anticompetitive effects. *In re E.I. DuPont de Nemours & Co.*, [1979-83 Transfer Binder] Trade Reg. Rep. (CCH) ¶ 21,770 at 21,960, 21,982 n.38 (1980). As the FTC recognized in *Dupont*, there is a danger in focusing only on efficiencies—the benefit side of the equation—to the exclusion of possibly destructive effects on competition.

[T]he actions of the would-be monopolist may enhance efficiency or product performance, albeit marginally, although the overall competitive effect is decidedly negative . . . Moreover, behavior that is rational for a firm with little or no market power may nevertheless produce substantial and unnecessary anticompetitive effects when wielded by a firm with considerable market clout.

In re DuPont at 21,978. See also *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 274-75 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980) (unlawful use of monopoly power may be shown by conduct dependent on monopoly power for success); *Telex Corp. v. IBM*, 510 F.2d 894 (10th Cir.), cert. dism'd, 423 U.S. 802 (1975).

Thus, the role of the fact finder to weigh the putative efficiencies and competitive benefits of challenged conduct against the alleged exclusionary characteristics and effects of that conduct is paramount. See *Greyhound Computer Corp. v. IBM Corp.*, 559 F.2d 488 (9th Cir. 1977), cert. denied, 434 U.S. 1040 (1978); *Transamerica Com-*

puter Co. v. IBM Corp., 481 F. Supp. 965 (N.D. Cal. 1979). The danger of condemning conduct that is actually beneficial to consumers is controlled in such cases, as in all Sherman Act cases, by the requirement of proving antitrust injury.

The court of appeals believed its analysis to be compelled by this Court's reasoning in *Aspen Skiing*. But the issue in *Aspen Skiing* was not simply the petitioner's conceded lack of business justification for its conduct; it was, instead, whether the evidence as whole was sufficient to support the jury's verdict in favor of the respondent. 472 U.S. at 599, 610-11. Indeed, the Court's statement that the jury's verdict was "strongly supported by Ski Co.'s failure to offer any efficiency justification whatever for its . . . conduct", *id.* at 608, implied that, if such a showing had been made, it would have been for the jury to evaluate. Nowhere did the Court suggest that any colorable justification would have preempted all of the plaintiff's evidence.¹⁴ What this Court did recognize was the importance of harm to consumers. *Id.* at 606.

C. The Court of Appeals Failed to Recognize as a Factual Matter, and thus Immunized as a Matter of Law, a Classic Instance of Non-price Predation, by which a Monopolist Raised its Rivals' Costs, Entrenched its Position as the Dominant Marketer of Physician Services, and Raised the Cost of Health Care and Health Insurance

The health care industry historically has been marked by a lack of price competition in both the financing and delivery of health services. Miller, *Vertical Restraints*

¹⁴ Similarly, it cannot be seriously contended that this Court's finding of attempted monopolization in *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), would have been different if the defendant newspaper had asserted that its new policy would induce some advertisers to place all of their ads with it, thus offsetting the revenue it could expect to lose from those who chose to patronize the radio station exclusively.

and *Powerful Health Insurers* at 195. In many states, including Rhode Island, nonprofit health service plans (i.e., Blue Cross and Blue Shield plans) have garnered a dominant position in the health financing market, attributable, *inter alia*, to their provider-controlled origins, tax and regulatory advantages, and direct contractual relationships with physicians and hospitals. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers* at 148-49. Effective competition with these plans is a recent phenomenon, largely attributable to the growth of integrated financing and delivery arrangements, such as health maintenance organizations, e.g., Ocean State. Miller, *Vertical Restraints and Powerful Health Insurers* at 200-04. Indeed, it has been suggested that HMOs represent the only viable competitive threat to entrenched Blue Cross plans. *Reazin*, 663 F. Supp. at 1417.

HMO competition has been encouraged, in part, because of the enormous economic significance of the health care financing industry.¹⁵ HMOs compete by creating incentives for providers to practice cost-effective medicine. Those incentives (in this case, the Ocean State "withhold") are the core of Blue Cross' attack on Ocean State. Far from reducing costs to consumers, Blue Cross' strategy allowed it to raise Ocean State's costs, suppress competition among physicians, and raise prices to consumers, or so the trier of fact should have been permitted to determine.

Historically, direct-contracting insurers (predominantly Blue Cross/Blue Shield plans) have fulfilled their role as a "purchaser" (or, more accurately, as a "broker" or "marketeer") of provider services in one of two ways. Such plans may act to buy services on behalf of their subscribers or they may act to sell services on behalf of

¹⁵ Total 1987 expenditures for private health insurance exceeded \$157 billion. Levit, Freedland, and Waldo, *Health Spending and Ability to Pay: Business, Individuals and Government*, 10 *Health Care Financing Review 1* (Spring 1989).

their contracting providers.¹⁶ The dichotomy between the role of joint selling agent and the role of joint purchasing agent was identified succinctly by the Seventh Circuit in *Ball Memorial Hospital v. Mutual Hospital Ins. Co.*, 784 F.2d 1325 (7th Cir. 1986). That case addressed the propriety of a dominant Blue Cross plan's decision to implement a so-called "preferred provider" system of selective contracting with hospitals based on competitive bidding. The court, in upholding the plan's actions as a legitimate purchasing arrangement on behalf of the plan subscribers, specifically quoted an internal policy document of the Indiana Blue Cross plan recommending that the plan, for the first time, "use its market position . . . to negotiate lower fees for provider services." *Id.* at 1337-38. That decision was a considered response to competitive pressures in the Indiana health insurance market. *Id.* at 1332.

Likewise, in *Kartell*, the First Circuit correctly characterized the Massachusetts Blue Shield plan's ban on "balance billing", which applied uniformly to all participating physicians *and* which resulted in lower charges to the plan's subscribers, as a legitimate action to obtain the best prices for physician services. Significantly, there was no evidence in *Kartell* that price competition in the

¹⁶ Although many courts have assumed the former characterization to be true, the latter role—as a concerted selling agency—historically was predominant. "Blue" plans originally were governed by their participating providers. Even after provider control of such plans passed from prevalence, it remained in the plans' interests to continue as the providers' joint selling agents. That is, having gained significant market share through historical tax and regulatory advantages, as well as their direct contracting relationships with providers, such plans evidenced a willingness to share monopoly profits with providers in order to maintain their provider networks and hence, their market shares. As regulated non-profit entities, the "Blue" plans historically faced lesser incentives to maximize "pure" profits and greater incentives to maximize total revenue and market share. See *Havighurst, The Questionable Cost Containment Record of Commercial Health Insurers in Health Care in America* 221, 248-51 (Frech, ed. 1988).

physician services market was restricted by the Blue Shield's payment practice.

In uncritically characterizing the Rhode Island Blue Cross plan as a "purchaser" of health services, the court below failed to recognize the adverse effect which Prudent Buyer had on consumers by stifling price competition in the physician services market, which in turn permitted Blue Cross to profitably raise prices in the health insurance market. The court flatly rejected the possibility that Blue Cross used its monopoly power to preclude competition by forcing its contracting physicians to cease dealing with Blue Cross' competitor, unless that competitor increased its payments to physicians. 883 F.2d at 1113 n.12.

It cannot be assumed that Blue Cross' control of the physician services market is benign simply because Blue Cross has some attributes of a "buyer." Where an insurer has market power in *both* the sale of insurance and the purchase of provider services, the potential for improper use of market power is great. Miller, *Vertical Restraints and Powerful Health Insurers* at 207. The fact that Blue Cross is an economic force in the physician services market, of course, is directly attributable to its monopoly in the health insurance market. Its position as a monopoly broker of physician services, in turn, preserves its health insurance monopoly by allowing it to drive up its competitors' costs. Thus, consumers are injured as clearly by reduced competition in the marketing of physician services as they are by reduced competition in the marketing of health plans.¹⁷ The Court of Appeals' failure to consider, let alone appreciate, the interrelated effects of Blue Cross' dual monopoly power has given

¹⁷ "The exercise of market power . . . does not require that a firm also have the ability to raise price by restricting its own output unilaterally. A firm also can exercise market power by raising competitors' costs and thereby inducing them to restrict their production or exit, which causes the market price of their output to raise." Krattenmaker & Salop, *Analyzing Anticompetitive Exclusion* at 79.

Blue Cross, and monopoly insurers generally, an enormous and inappropriate shield against Section 2 claims.¹⁸

There was ample evidence in this case from which the jury could, and did, conclude that Blue Cross' purported business justifications were marginal rationalizations of otherwise exclusionary conduct. Indeed, Blue Cross conceded that Prudent Buyer was not motivated by concern for cost savings, and the savings achieved through Prudent Buyer were minimal—less than one half of one percent of total expenditures. Moreover, the evidence showed that Prudent Buyer was imposed only against physicians contracting with Ocean State and not those selling their services through any other health plan.

Further, Blue Cross actually attempted to *minimize* its cost savings. Specifically, it encouraged physicians to avoid the impact of Prudent Buyer by terminating their relationships with Ocean State, and purposefully extended the time in which physicians were permitted to make that decision. In other words, the Prudent Buyer program was equally, and indeed more rationally, capable of being viewed as an offer to continue to *pay more* to physicians who agreed not to deal with Ocean State rather than an attempt to pay less for physician services

¹⁸ Similarly, in *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80 (3d Cir.), cert. denied, 414 U.S. 1093 (1973), a case also relied upon by the Circuit Court, the Third Circuit made a comparable error in analysis in concluding that Blue Cross of Pennsylvania was merely engaged in "hard bargaining". The evidence recited in the Third Circuit's opinion in *Travelers* hardly permits any other interpretation than that the Blue Cross plan, instead of exerting its market power against the hospitals as a true "Prudent Buyer" seeking to get maximum discounts, elected to accept a lesser discount negotiated with the state hospital association and to count on the hospitals collectively to see that its competitors got no discounts at all. Professors Krattenmaker and Salop have observed that cultivating a cartel of suppliers with which one's competitors must contend is an excellent strategy for "raising rivals' costs." The *Travelers* case is a classic instance of this kind of exclusionary conduct. See Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers* at 248-54. Regrettably, the *Travelers* court did not recognize it as such.

generally. This evidence alone speaks volumes in rebuttal to any putative efficiency justification.

Finally, the evidence showed not only that Ocean State's costs were increased as a direct result of this conduct, but that Blue Cross was able to increase its prices and profits. Consumers did not benefit from the alleged "efficiencies." This evidence, likewise, is to be ignored under the First Circuit's special rule, notwithstanding that it goes to the essence of antitrust injury. 883 F.2d at 1111 n.11.

Clearly, the court below has distorted the basic principles of Section 2 jurisprudence. Absent clarification, monopoly buyers in general and monopoly health insurers in particular are effectively unfettered by Section 2.

II. THE DECISION BELOW EXTENDS THE REACH OF THE McCARRAN-FERGUSON EXEMPTION TOO BROADLY

A. The McCarran-Ferguson Act Should Not Be Interpreted to Preclude Consideration of Exempt Conduct That Is Intertwined With Non-Exempt Conduct

The court of appeals' failure to identify the exclusionary nature of Prudent Buyer is magnified by its refusal to examine the relevance of the other two-thirds of Blue Cross' strategic behavior. Under the antitrust laws, the character and effect of challenged conduct is not to be judged "by dismembering it and viewing its separate parts, but only by looking at it as a whole." *United States v. Patten*, 226 U.S. 525, 544 (1913). See also *Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 699 (1962); *Aspen Skiing*, 472 U.S. at 599, 610-11.

The Ocean State look-alike product, HealthMate, and the discriminatory pricing mechanism, Adverse Selection, were integral to the overall success of Blue Cross' design to eliminate Ocean State as a competitor. The court of appeals surgically separated the three aspects of Blue Cross' strategy and determined that HealthMate and

Adverse Selection fell within the "business of insurance" exemption of the McCarran-Ferguson Act. On that basis, it declined to consider their import further in regard to Blue Cross' conduct. In so doing, the court interpreted McCarran-Ferguson not only to bar consideration of those elements by the fact-finder in evaluating the legitimacy of the non-exempt Prudent Buyer strategy, but also to bar their consideration by the *court* in determining whether Blue Cross' conduct as to Prudent Buyer had to be characterized as *per se* legal.

Clearly, the existence or absence of a colorable business justification is a question more suitably answered in the context of Blue Cross' overall "plan of attack" than by reference to any single element of that conduct.¹⁹ The purpose of the McCarran-Ferguson statute is to prevent "impairment" of state insurance regulation, *i.e.*, to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *Securities and Exchange Cmsn. v. National Securities, Inc.*, 393 U.S. 453 (1969); *Prudential Ins. Co. v. Benjamin*, 328 U.S. 408 (1946). However, a state's ability to sanction specific conduct under its regulatory scheme should not be deemed "impaired" simply because evidence of that conduct is to be examined by a court in judging the legality of related conduct outside the "business of insurance"—*i.e.*, with regard to "Prudent Buyer."²⁰

¹⁹ There was clear evidence in this case that neither HealthMate nor Adverse Selection were devised for legitimate business purposes. HealthMate was known from the outset to be unprofitable to Blue Cross and, indeed, it performed as predicted. It was never considered a long-term business product but only a "fighting ship" to attack Ocean State. Adverse Selection, likewise, was shown to be the result of arbitrary actuarial assumptions and statistical manipulations. Its purpose was to impose financial penalties on employers who offered Ocean State as an alternative to Blue Cross, as the court of appeals itself recognized.

²⁰ Whether HealthMate and Adverse Selection ultimately had the general approval of the State is not dispositive of their relevance

B. The Decision Below Reflects the Lack of Standards for Applying the “Coercion” Exception to the McCarran-Ferguson Act

The McCarran-Ferguson Act expressly excludes from its Sherman Act exemption “any . . . act of boycott, coercion, or intimidation.” 15 U.S.C. § 1013(b). In summarily concluding that Blue Cross’ economic pressure directed against employers offering the Ocean State plan to their employees did not amount to “coercion” within the meaning of the Act, the court below distorted the definition of coercion developed elsewhere in antitrust law. The court, thereby, inappropriately expanded the McCarran-Ferguson exemption—an exemption that is to be construed narrowly. *Royal Drug*, 440 U.S. at 231.

The court below recognized the dearth of case law interpreting “coercion” in the McCarran-Ferguson context. 883 F.2d at 1109 n.9. It is clear, however, that the terms used in § 1013(b) are to be construed in light of the “tradition of meaning” given them under the Clayton and Sherman Acts. *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1978). The term “coercion” has been used by this Court in a variety of contexts to define conduct that is harmful to competition. The principal definitional issue is to distinguish actionable “coercion” from mere “persuasion” or “argument.” *Ford Motor Co. v. United States*, 335 U.S. 303, 316-17 (1948).

Generally, the line between argument and coercion has been deemed to be crossed when economic power is used as a “club” to force a result that would not otherwise have been accomplished. *Id.* at 316-20 (approving jury instructions to that effect). “Coercive activity that prevents its victims from making free choices between mar-

to the overall antitrust issue. State insurance regulators have no mandate to protect competition in provider service markets. Nor does state approval depend on the purpose of the conduct or its effect on overall price levels in the market for health insurance. Thus, consideration of the HealthMate and Adverse Selection as evidence of Blue Cross’ composite design, and efficiency rationale is appropriate.

ket alternatives is inherently destructive of competitive conditions and may be condemned without proof of its actual market effect." *Associated Gen. Contractors of Cal. v. California State Council of Carpenters*, 459 U.S. 519, 528 (1983). This Court has recognized that arbitrary and unreasonable price differentials designed to penalize those who deal with an actor's competitors constitute "coercive" conduct actionable under the Sherman Act. *United States Navigation Co. v. Cunard S.S. Co.*, 284 U.S. 474, 479-80 (1932).

The court below plainly misconstrued the concept of coercion in light of the facts presented. Blue Cross' strategy of charging higher prices only to employers who offered Ocean State as an alternative to Blue Cross was designed to force those employers to forego their choice to offer a competing health plan as the court below conceded. 883 F.2d at 1104 n.4. The coercive intent of this strategy was demonstrated at trial by evidence that the "estimates" of Ocean State enrollment and other "actuarial" assumptions behind the Adverse Selection discriminatory pricing scheme were arbitrary. This was not, as the court below suggested, an attempt to "lure" employers away from Ocean State by persuading them of the competitive merits of Blue Cross. Rather, it was a bald effort to suppress competition on the merits through economic duress.

C. This Court Should Reconsider the Extent to Which Passive State Regulation Is Sufficient to Invoke the McCarran-Ferguson Exemption

The court below determined that both HealthMate and Adverse Selection fell within the "business of insurance" for purposes of McCarran-Ferguson exemption.²¹ It did so in the face of evidence that the initiation of Adverse

²¹ The appellate court reached this determination notwithstanding Blue Cross' failure to raise the issue on appeal with respect to HealthMate. 883 F.2d at 1107 n.6.

Selection preceded the Rhode Island Department of Business Regulation ("DBR") approval and that DBR was never required to approve the specific elements of Health-Mate and Adverse Selection. 883 F.2d at 1103 n.1, 1108-09. This holding raises two issues which merit consideration by this Court.

First, the holding below extends the shield of the McCarran-Ferguson Act to conduct (Adverse Selection) that was undertaken in advance of the required state regulatory approval. As the exception for acts of boycott and coercion indicates, the McCarran exemption cannot be used to shield one illegal act with another. This conclusion has been suggested in other contexts.²²

A second, and broader, question raised by the decision below is whether the McCarran-Ferguson exemption should continue to be liberally construed as to exclusionary conduct that is not actively supervised by the state. Historically, this Court has indicated that the existence of a general regulatory scheme is sufficient to satisfy the "regulated by state law" requirement of the McCarran-Ferguson Act. *FTC v. National Casualty Co.*, 357 U.S. 560 (1958). The lower courts, over time, have construed this teaching most generously to the benefit of insurers.²³

²² See *United States v. Sylvanus*, 192 F.2d 96 (7th Cir. 1951), cert. denied, 342 U.S. 943 (1952) (McCarran-Ferguson Act does not bar mail fraud prosecution against insurer; relying in part on finding that insurer's conduct was in derogation of state regulatory directives); *Washburn v. Brown*, 1986 WL 7062 (N.D. Ill. 1986) (insurer's scheme to defraud state insurance department and policy holders by misrepresenting compliance with regulatory requirements not exempted from RICO suit by McCarran-Ferguson Act.) Like the defendants in *Sylvanus* and *Washburn*, Blue Cross seeks the protection of a regulatory scheme which it flouted in order to undertake its exclusionary conduct.

²³ Thus, the exemption has been applied in cases where no statute or regulation specifically governs the challenged practice, *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364 (E.D. Pa. 1976), as well as to cases in which state regulations are not enforced. *Lawyers Title Co. v. St. Paul Title Ins. Corp.*, 526 F.2d 795 (8th Cir. 1975). Indeed, entirely permissive regulatory schemes have been held to

In view of the narrow construction of the "business of insurance" emphasized in more recent decisions of this Court, a continued *laissez-faire* approach to the state regulation requirement is incongruous.

In this regard, it may be observed that the McCarran-Ferguson approach to state regulation is decidedly less restrictive than that required by the state action doctrine. But the two exemptions, even though distinct, are virtually identical in purpose. Indeed, courts have invoked both doctrines in a combined analysis. *See, e.g., Allstate Insurance Co. v. Lanier*, 361 F.2d 870, 872-73 (4th Cir. 1966).

The state supervision requirement has been the focus of recent state action cases in this Court. *Patrick v. Burget*, 486 U.S. 94, 108 S. Ct. 1658 (1988); *California Retail Liquor Dealers Ass'n v. Mideal Aluminum, Inc.*, 445 U.S. 97 (1980). Those decisions indicate a view that federal-state conflict is more likely to be avoided, and that abuses are better controlled, when the state evinces an active commitment to its regulatory objectives. "Absent such a program of supervision, there is no realistic assurance that a private party's anticompetitive conduct promotes state policy, rather than merely the party's individual interests." *Patrick*, 108 S. Ct. at 1663.

Presently, however, such assurance is lacking with regard to the actions of private insurers. No specific articulation or supervision is necessary to sanction competitive abuses as long as the conduct can be squeezed within the general regulation of the business of insurance.²⁴ Thus, the sufficiency of state regulation has been

preclude federal causes of action. *State of Ohio v. Ohio Med. Indem., Inc.*, 1976-2 Trade Cas (CCH) ¶ 61,128 at 70,110 (S.D. Ohio).

²⁴ That fact has troubled the courts. *See, e.g., Ohio Med. Indem.*, 1976-2 Trade Cas. at 70,113 ("Were the Court writing on a clean slate, it would be persuaded that the State of Ohio does not 'regulate' the business of . . . insurance as it relates to the allegations in the complaint.") *In re Aviation Ins. Indus.*, 183 F. Supp. 374 (S.D.N.Y. 1960) (holding exemption inapplicable where state regulation not specifically directed to subject matter in question).

raised before this Court as recently as *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), but ultimately was not the basis for decision in that case. 458 U.S. at 134 n.9.

The significance of the state regulation requirement lies in the fact that insurance regulation, in and of itself, promotes objectives that are not necessarily congruous with those of the antitrust laws, and, to the extent McCarran-Ferguson is applicable, an explicit trade-off is made between state regulatory objectives and price competition. Moreover, to the extent insurance practices restrain trade in related non-insurance markets—*e.g.*, the market for physician services—where state regulators have no mandate to protect consumer welfare, the need for, and legitimacy of, regulatory immunity is further attenuated. Thus, the clarity of the state commitment to regulate the conduct in question is critical.

The decision below well illustrates the problems which the historical interpretation of “state regulation” has engendered. The ultimate “approval” of Adverse Selection by the state—sought only after the state directed Blue Cross to do so—consisted solely of the approval of a rating formula. Blue Cross remained free, un-supervised by the state, to manipulate its estimates of subscriber loss and health status, *i.e.*, the numbers to which the formula would be applied, in order to achieve a coercive price differential to be charged employers that offered the competing Ocean State plan. That unregulated element of Adverse Selection, however, was the relevant conduct in Blue Cross’ overall predatory strategy, and nothing in state regulation supervised the outcome.

Likewise, the HealthMate product merely was approved for sale by the State of Rhode Island. The manner in which it was marketed—only to employers that offered Ocean State—and the price at which it was offered were not approved. The decision below plainly illustrates how

effectively insurers may use unsupervised conduct to harm competition.

III. THIS COURT SHOULD GIVE EFFECT TO THE INDEPENDENT OBJECTIVES OF STATE TORT LAW

By determining that the Sherman Act controls the disposition of Ocean State's tort claim, both the district court and the court of appeals inappropriately imposed a federal standard on state tort law. In light of the frequency with which pendent state law claims are raised in federal antitrust suits, this Court should review the holding below and address the obligation to give effect to the acts of the state legislatures. In Rhode Island, the tort of interference with contractual relationships is defined as an "unfair" act which diminishes the value of a contract. *Smith Development Corp. v. Bilow Enters., Inc.*, 112 R.I. 203, 308 A.2d 477 (1973). Although conduct which is independently wrongful—e.g., because it violates the antitrust laws—may be deemed presumptively ill-motivated for purposes of tort law, *see* Restatement (Second) of Torts § 767, comment d, it does not follow that a finding that the Sherman Act has not been violated is dispositive of a tort claim arising from the same conduct. The concept of "unfair" competition is decidedly different in scope and objective from the antitrust laws. *See* McCarthy, Trademarks and Unfair Competition § 1:14. Accordingly, the use of the Sherman Act to interpret and decide the pendent tort claim denied Ocean State the protection of state law to which it was entitled. Federal courts should not act so precipitously in respect to state interests.

CONCLUSION

The decision below creates a special rule of *per se* legality which effectively immunizes exclusionary conduct by a health insurer from Sherman Act scrutiny. The same analytical failing led the court below to misconstrue critical aspects of the McCarran-Ferguson Act exemption, and to ignore independent principles of state tort law. For the reasons stated, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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APPENDICES



APPENDIX A

**UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT**

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs-Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

Appeal from the United States District Court
for the District of Rhode Island
[Hon. Francis J. Doyle, *U.S. District Judge*]

Before
Campbell, *Chief Judge*,
Bownes, *Circuit Judge*,
and Caffrey,* *Senior District Judge*.

Stuart M. Gerson with whom William G. Kopit, Epstein, Becker & Green, P.C., Thomas E. Lynch and Lynch and Greenfield were on brief for appellants.

Steven E. Snow with whom James E. Purcell, Partridge, Snow & Hahn, Elia Germani, Joshua F. Greenberg, Michael Malina, and Kaye, Scholer, Fierman, Hays & Handler were on brief for appellee.

August 21, 1989

* Of the District of Massachusetts, sitting by designation.

CAMPBELL, Chief Judge. Plaintiffs, Ocean State Physicians Health Plan, Inc. ("Ocean State") and a certified class of Ocean State's participating physicians, brought suit against Blue Cross & Blue Shield of Rhode Island ("Blue Cross"), alleging that Blue Cross had acted unlawfully to exclude Ocean State from the health care insurance marketplace. A jury found that Blue Cross was guilty of violating section 2 of the Sherman Act, 15 U.S.C. 2 (1982) and also was liable under Rhode Island common law for tortiously interfering with the contractual relationships between Ocean State and the physicians. The district court subsequently ruled, however, that the challenged conduct was legitimate competitive activity of a sort that is favored—not prohibited—by the antitrust laws. Accordingly, the court granted judgment notwithstanding the verdict to Blue Cross on both the antitrust and tortious interference claims. We affirm the district court's judgment.

I. FACTUAL BACKGROUND

Defendant Blue Cross, a non-profit corporation established in 1939, has long been the largest health insurer in Rhode Island. It purchases health services from physicians, hospitals, and other health care providers on behalf of its subscribers. Blue Cross underwrites the cost of these purchases by spreading the risk of health care expenses among its subscriber groups. Plaintiff Ocean State is a for-profit health maintenance organization ("HMO") that began operations in 1984. Like Blue Cross, Ocean State contracts with physicians to provide medical care to its subscribers, and then pays its contracted physicians on a fee-for-service basis. While Blue Cross will reimburse its subscribers even for certain services performed by non-participating physicians, Ocean State does not pay for services by non-participating physicians. Eighty percent of the shares of the Ocean State corporation are owned by its participating physicians. A physician may participate in more than one

health insurance program. Thus, a physician may contract with Blue Cross, with Ocean State, or with both.

From its inception, Ocean State grew rapidly. Like Blue Cross, it was offered to subscribers through employers. Apparently because Ocean State provided more coverage and charged lower premiums, many subscribers switched from Blue Cross to Ocean State. By the spring of 1986, Blue Cross had lost approximately 30,000 of its 543,015 enrollees, while Ocean State's enrollment had exceeded all expectations, growing to 70,000. See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 692 F. Supp. 52, 57 (D.R.I. 1988). Because Blue Cross was experiencing financial problems, it had to raise its premiums in order to maintain adequate financial reserves. As it raised its premiums, it lost more enrollees—which, in turn, forced further rate increases. In short, Blue Cross “was faced with a serious competitive problem.” *Ocean State*, 692 F. Supp. at 57.

In the spring of 1986, to meet the challenge presented by Ocean State, Blue Cross instituted a three-pronged attack:

First, Blue Cross launched its own HMO “look-alike,” dubbed HealthMate, which it marketed to employers who were offering the Ocean State plan to their employees. Like Ocean State, HealthMate provided 15 percent more coverage than the standard Blue Cross plan, including such added benefits as office visits, prescription drugs, and “good health” benefits. Like Ocean State, but unlike traditional Blue Cross, HealthMate paid only for services provided by participating physicians. In those employer groups in which employees were required to contribute to their premiums, HealthMate was offered at 5 percent below the cost of traditional Blue Cross. 692 F. Supp. at 58.

Second, Blue Cross instituted an “adverse selection” policy of pricing. “Adverse selection” refers to the

tendency for younger and healthier people to opt for HMOs such as Ocean State when they are made available, leaving older and sicker people (on the average) in the standard Blue Cross pool. Because of such adverse selection, Blue Cross expected the health care costs for standard Blue Cross to be higher in those employer groups that offered an HMO option than in those employer groups that did not. With the approval of the Rhode Island Department of Business Regulation ("DBR"), Blue Cross instituted a pricing plan that took account of this projected difference in health expenses.¹ Under this policy, employers were offered three different rates for traditional Blue Cross coverage. The rate was lowest for an employer who offered *only* traditional Blue Cross, intermediate for an employer who also offered a competing HMO (usually Ocean State) and HealthMate, and highest for an employer who also offered a competing HMO but declined to offer HealthMate.

Third, Blue Cross initiated a policy, which it called "Prudent Buyer," of not paying a physician more for any service or procedure than that physician was accepting from any other health care cost provider (such as Ocean State). Blue Cross established this policy after it became apparent that Ocean State's contracting physicians were accepting about 20 percent less for their services from Ocean State than they were receiving from Blue Cross. Ocean State had withheld 20 percent of its physicians' fees in 1985, with the expectation that if the corporation made a profit the withhold would be returned. Ocean State did not turn a profit, however, and the withhold was not returned. In 1986 Ocean State again withheld 20 percent of its physicians fees, which it again failed

¹ Blue Cross established the adverse selection policy in June 1986, without approval from DBR. In October 1986, DBR ordered Blue Cross to suspend the policy until it obtained DBR approval. On November 12, 1986, the DBR approved Blue Cross's rate formula, and Blue Cross resumed its use.

to return after the end of the year. In order to ensure that it was getting the physicians' best prices, Blue Cross required each of its participating physicians to certify that he or she was not accepting any lower fees from other providers than he or she was receiving from Blue Cross for the same service. If the provider failed to provide such certification, Blue Cross reduced that physician's fees by 20 percent. As a result of the Prudent Buyer policy, Blue Cross achieved significant cost savings. After the implementation of Prudent Buyer, about 350 of Ocean State's 1200 physicians resigned, in many cases apparently in order to avoid a reduction in their Blue Cross fees.

II. PROCEDURAL BACKGROUND

Ocean State, together with a certified class of its participating physicians, brought this suit against Blue Cross. Ocean State² alleged that Blue Cross's conduct violated, *inter alia*, section 2 of the Sherman Act, which makes it unlawful to "monopolize . . . any part of the trade or commerce among the several States." 15 U.S.C. § 2.³ Ocean State charged that Blue Cross launched

² Here and at other points, in this opinion we use the term "Ocean State" to refer collectively to both plaintiffs—Ocean State itself and the class of participating physicians.

³ Under section 4 of the Clayton Act, 15 U.S.C. § 15 (1982), any person injured by such unlawful monopolization may bring suit for treble damages, and under section 16 of the Clayton Act, 15 U.S.C. § 26 (1982), any person threatened with such injury may sue for injunctive relief.

Ocean State also claimed that Blue Cross had violated section 1 of the Sherman Act, 15 U.S.C. § 1 (1982), which prohibits contracts, combinations, and conspiracies in restraint of trade. Ocean State alleged that Blue Cross had violated section 1 by (1) attaining monopoly power through a merger between Blue Cross and Blue Shield in 1982, and (2) conspiring with the Rhode Island Group Health Association ("RIGHA"), the only HMO operating in Rhode Island before 1984, to control hospital discounts. At the close of the plaintiffs' case, the district court directed a verdict in

HealthMate not because it was a viable long-term product, but in order to put Ocean State out of business. Through the adverse selection policy, Ocean State claimed, Blue Cross was able to raise its rates for standard Blue Cross for employer groups offering HealthMate—which, in turn, influenced employers not to make HealthMate available.* Finally, Ocean State claimed that Blue Cross instituted the Prudent Buyer policy not in order to save money, but rather to induce physicians to resign from Ocean State. Plaintiffs also raised a pendent state law claim: that Blue Cross's conduct tortiously interfered with the contractual relationships between Ocean State and the members of the class of Ocean State physicians.

After a lengthy trial, the jury found Blue Cross "guilty" on the section 2 claim, but it awarded no damages on this claim. The jury also found that Blue Cross

favor of Blue Cross on the section 1 claims. The court ruled that there was no evidence that the Blue Cross-Blue Shield merger had an anticompetitive effect, and that there was no evidence that plaintiffs were injured as a result of the agreement between Blue Cross and RIGHA. Ocean State does not seriously challenge this directed verdict on appeal. In a footnote to its brief, Ocean State suggests only that if this court were to order a new trial on antitrust matters, plaintiffs should be entitled to press their section 1 claims. At oral argument, Ocean State's counsel said that it had addressed the section 1 claims "en passant." This "en passant" presentation did not suffice to preserve the section 1 issue on appeal, and therefore we will not consider it further.

* It might seem incongruous at first blush for Ocean State to allege that Blue Cross engaged in anticompetitive behavior by *raising* its rates. Such allegations of anticompetitive conduct are usually reserved for cases in which companies *lower* their rates, incurring short-term losses for the purpose of undercutting competitors and putting them out of business. Here, however, Ocean State argues plausibly that many employers felt committed to offer Blue Cross to their employees. Since their Blue Cross rates would increase if they also offered Ocean State, these employers allegedly felt pressure not to adopt (or to drop) Ocean State in order to keep their Blue Cross rates down. The personnel manager of one company testified to this effect at trial.

had tortiously interfered with plaintiffs' contractual relationships. On the latter claim it awarded the Ocean State Physicians Health Plan \$947,000 in compensatory damages and \$250,000 in punitive damages; and it awarded the members of the physician Class \$1,746,437 in compensatory damages. Following the verdict, Blue Cross moved for judgment notwithstanding the verdict on both claims and, in the alternative, for a new trial on the tortious interference claim. Ocean State, for its part, moved for an injunction against Blue Cross's continuation of the challenged policies, as well as for a \$1.9 million additur to the jury award to the physician class.

In its opinion, 692 F. Supp. at 74, the district court granted Blue Cross's motion for judgment notwithstanding the verdict on both the antitrust and tortious interference claims. The court reached its result with respect to the antitrust claims on alternative grounds. First, the court reasoned that the jury's award of "no damages" on the antitrust claim meant that plaintiffs had failed to prove that they had been injured by any illegal conduct by Blue Cross. Second, the court held that, quite aside from the "no damages" verdict, Ocean State plaintiffs had failed to show that Blue Cross's actions were anything other than legitimate acts of competition. Having determined that Blue Cross had not violated the antitrust laws, the district court also granted Blue Cross judgment notwithstanding the verdict on the state law claim of interference with contractual relationship relationships. The court noted that Blue Cross's policies were "*justified responses to competitive conditions*," *id.* at 73 (emphasis added), and therefore ~~could~~ not as a matter of law constitute tortious interference with contractual relationships. In light of these conclusions, the district court also denied Ocean State's motions for injunctive relief and for an additur. Ocean State appeals from these rulings of the district court.

III. STANDARD OF REVIEW

In ruling on a defendant's motion for judgment notwithstanding the verdict, the district court must evaluate the evidence in the light most favorable to plaintiffs. *Rios v. Empresas Lineas Maritimas Argentinas*, 575 F.2d 986, 989 (1st Cir. 1978). "The motion is properly granted only when, as a matter of law, no conclusion but one can be drawn." *Id.* at 990. We adopt the same standard in reviewing the district court's judgment. At the same time, we note that "the trial court as well as this court has an obligation to render judgment as a matter of law when it is clear from the evidence that such is required." *United States v. Articles of Drug Consisting of the Following: 5,906 Boxes*, 745 F.2d 105, 113 (1st Cir. 1984).

IV. THE ANTITRUST CLAIM

In addressing Ocean State's antitrust claim, we first consider the effects on that claim of the jury's "guilty/no damages" verdict. We decline to utilize the jury's failure to award damages as a basis for upholding the lower court's entry of judgment notwithstanding the verdict for Blue Cross. We then consider the applicability of the McCarran-Ferguson Act, which under certain circumstances exempts the "business of insurance" from the antitrust laws. We conclude that by reason of McCarran-Ferguson both HealthMate and the adverse selection policy are exempt from antitrust scrutiny. Finally, we consider whether the Prudent Buyer policy can as a matter of law be found to be an instance of prohibited monopolization, rather than legitimate competitive activity, and we conclude that it cannot.

A. *The "Guilty/No Damages" Verdict*

As a general rule, a verdict of liability with no damages may require that judgment be entered for the defendant. This court has held, for example, that when a jury found in favor of the plaintiff but assessed "zero"

damages under a state automobile dealers act and related tort and contract claims, the "plaintiff ha[d] failed to establish an essential part of its proof [*i.e.*, a showing of damages], and judgment should have been entered for defendant." *Poulin v. Chryler Corp.*, 861 F.2d 5, 7 (1st Cir. 1988) (citing *Association of Western Railways v. Riss & Co.*, 299 F.2d 133, 135 (D.C. Cir.), cert. denied, 370 U.S. 916 (1962)). In *Western Railways*, similarly, the court held that defendants were entitled to judgments on claims raised under sections 1 and 2 of the Sherman Act because, although the jury had found "for" the plaintiff, it awarded no damages.

Despite this general rule, however, we hesitate to affirm the district court's judgment on the ground that the jury found Blue Cross "guilty" but did not award damages. The instant case presents two difficulties to that approach which—while we do not decide—cause us to turn elsewhere.

First, the present plaintiffs—unlike the plaintiff in *Poulin*—sought not only damages, but also injunctive relief. In a case of this sort, involving prayers for both damages and injunctive relief, a jury finding of liability is ordinarily a prerequisite to the court's equitable consideration of injunctive relief. See *Beacon Theatres, Inc., v. Westover*, 359 U.S. 500 (1959) (order of trial must be arranged so that any issues common to a legal claim and an equitable claim are tried to a jury first, with the equitable claim resolved subsequently in light of the determination of the jury). But a finding of damages is not a necessary prerequisite to injunctive relief in a case like the present one. Section 4 of the Clayton Act, 15 U.S.C. § 15, under which Ocean State sought treble damages, requires proof of "some damage." *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 114 n.9 (1969) (emphasis added). But section 16 of the Clayton Act, 15 U.S.C. § 26, under which plaintiffs sought injunctive relief, requires only "threatened loss or damages by

a violation of the antitrust laws" (emphasis added). See *Cargill, Inc. v. Monfort of Colorado, Inc.*, 479 U.S. 104, 111, 107 S. Ct. 484, 489 (1986) ("§ 4 requires a plaintiff to show actual injury, but § 16 requires a showing only of 'threatened' loss or damage"). Under this standard, a finding of actual damages may not necessarily be required. Cf. *Home Placement Service, Inc. v. Providence Journal Co.*, 573 F. Supp. 1423 (D.R.I. 1983), *rev'd in part on other grounds*, 739 F2d 671 (1st Cir. 1984), *cert. denied*, 469 U.S. 1191 (1985) (granting permanent injunction to prevent future antitrust violations, despite a damages award of only \$3 in nominal damages). Therefore, the jury finding of liability but no damages on the antitrust claim arguably requires the lower court to consider awarding injunctive relief. If so, for us to determine whether or not the district court erred in denying Ocean State's motion for an injunction, we must deal first with the merits of the jury's finding of antitrust liability.

Second, although the jury awarded "no damages" on the antitrust claim, it awarded substantial damages to Ocean State and the physicians on the pendent state claim of interference with contractual relationships. Blue Cross and Ocean State agree that the antitrust and tortious interference claims were based on the same pattern of conduct. Moreover, the jury had evident difficulty in deciding how to allocate the damage award between the two claims. Common sense suggests that under these circumstances, the damage award for tortious interference may have represented the jury's assessment of antitrust injury as well.⁵ To the extent that this is likely, a

⁵ The jury initially awarded *each* plaintiff, Ocean State and the physician class, compensatory damages of \$2,693,437 and punitive damages of \$250,000, undifferentiated as to claim. Noting that Ocean State and the physicians allegedly suffered distinct injuries, the court instructed the jury that it must award damages separately for each plaintiff and for each claim. After further deliberation, the jury awarded Ocean State compensatory damages of \$947,000

new trial might be necessary in order to rule out the possibility that the jury's verdict was a product of confusion. By dealing with the finding of antitrust liability on its merits, we are able to avoid this problem. We turn, therefore, to the question whether, as a matter of law, an antitrust verdict in plaintiffs' favor could permissibly stand.

B. *The Effect of the McCarran-Ferguson Act*

The McCarran-Ferguson Act ("the Act"), 15 U.S.C. §§ 1012(b), 1013(b), exempts from the antitrust laws all conduct that is (1) part of the "business of insurance"; (2) "regulated by State law"; and (3) not in the form of "boycott, coercion, or intimidation." Blue Cross argued to the district court that both the introduction of HealthMate and the use of the adverse selection rate factors—but not the Prudent Buyer policy—were exempted from antitrust scrutiny by the Act.⁶ The district

and punitive damages of \$250,000 and awarded the physicians compensatory damages of \$1,746.437. But the verdict forms did not indicate whether the awards were for damages on the antitrust claim, the tortious interference claim, or both. The district court then instructed the jury that it must specify the claims upon which it awarded damages. Finally, on its third try, the jury awarded "no damages" on the antitrust claim and the same damages as on the second verdict form on the tortious interference claim. In light of the jury's evident difficulty in apportioning the damages between the two claims, it is altogether possible that the jury viewed the damages as stemming from *both* the antitrust violations and the tortious interference. Inasmuch as the jury had been instructed that it could not award damages twice for the same injury, it could not assign the damages to both claims. The jury was not instructed—as perhaps it should have been—that it could assign the same amount to each claim, with the proviso that any award reflecting the overlapping of the two claims was to be made once, not twice.

⁶ On this appeal Blue Cross presses its argument with respect to the use of the adverse selection factors, but not with respect to HealthMate. But Blue Cross raised the issue with respect to

court declined to rule on this argument. We find, however, that the McCarran-Ferguson exemption applies both to HealthMate and to the use of the adverse selection factors.

1. *The "business of insurance."* The central issue with respect to the applicability of the McCarran-Ferguson Act is whether HealthMate and adverse selection are part of the "business of insurance." 15 U.S.C. § 1012(b). The Supreme Court has identified "three criteria relevant in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws":

first, whether a particular practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, 129 (1982). See also *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 210-17 (1979). The Court went on to note that "none of these criteria is necessarily determinative in itself." *Pireno*, 458 U.S. at 129.

Both HealthMate and the adverse selection policy qualify as the "business of insurance" under these criteria. HealthMate is an insurance policy which operates by spreading policyholders' risk; adverse selection is a pricing policy that inherently involves risk-spreading. Both HealthMate and adverse selection directly involves the relationship between the insurer (Blue Cross) and the insured (its policyholders). Such policies are, more

HealthMate in the court below, and Ocean State responded to the argument with respect to HealthMate in its appellate brief. Therefore, we do not think that the argument with respect to HealthMate has been waived.

or less by definition, limited to entities in the "insurance industry" as broadly construed. *Accord Health Care Equalization Committee v. Iowa Medical Society*, 851 F.2d 1020, 1029 (8th Cir. 1988).

Ocean State argues that "service benefit plans," such as Blue Cross, should not be deemed insurers for McCarran-Ferguson purposes. It bases this argument on a misreading of *Royal Drug*, 440 U.S. 205. In that case, the Supreme Court characterized Blue Shield's contacts with its *health care providers* as "merely arrangements for the purchase of goods and services by Blue Shield." *Id.* at 214. But the Court took care to distinguish Blue Shield's provider contracts from its subscriber contracts:

This is not to say that the contracts offered by Blue Shield to its policyholders, as distinguished from its provider agreements . . . , may not be the 'business of insurance' within the meaning of the [McCarran-Ferguson] Act.

Id. at 230 n.37. This distinction was emphasized in Justice Brennan's dissenting opinion:

Neither the Court . . . nor the parties challenge the fact that the . . . policy offered by Blue Shield to its policyholders—as distinguished from the contract between Blue Shield and the [providers]—is the "business of insurance." Whatever the merits of scholastic argument over the technical definition of "insurance," the policy both transfers and distributes risk. The policyholder pays a sum certain—the premium—against the risk of the uncertain contingency of illness, and if the company has calculated correctly, the premiums of those who do not fall ill pay the costs of benefits above the premiums of those who do.

Id. at 239 (Brennan, J., dissenting) (citation omitted).

Since *Royal Drug*, the focus of the McCarran-Ferguson inquiry has been the nature of the conduct alleged to vio-

late the antitrust laws, not whether the defendant is a traditional insurance company.⁷ Accordingly, contracts between a Blue Cross plan and its subscribers have been found to be the "business of insurance" within the meaning of the Act. *See Health Care Equalization Committee*, 851 F.2d at 1020, 1028; *Anglin v. Blue Shield of Virginia*, 693 F.2d 315, 317-320 (4th Cir. 1982).

Ocean State also argues that Blue Cross's marketing and pricing practices with respect to HealthMate do not in themselves have the effect of transferring or spreading the policyholder's risk. But inasmuch as a health insurance policy is itself part of the "business of insurance," *see, e.g.*, *Health Care Equalization Committee*, 851 F.2d 1020, 1028; *Anglin*, 693 F.2d 315, 317-320, we believe that the marketing and pricing of such policies are also part of the same business. The exemption offered to state-regulated insurance activities by the McCarran-Ferguson Act would be thin indeed if it were deemed to cover the content of policies, but not the marketing and pricing activities which necessarily accompany these policies. Indeed, in *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), the Supreme Court noted that "the fixing of rates" and "[t]he selling and advertising of policies" are part of the "business of insurance" under the McCarran-Ferguson Act.

We conclude, therefore that both HealthMate and adverse selection are part of the "business of insurance" under the McCarran-Ferguson Act.

⁷ For this reason, Ocean State's observation that under Rhode Island law Blue Cross is considered not to be "part of the insurance industry," *Hospital Service Corp. v. West*, 112 R.I. 164, 178, 308 A.2d 489, 497 (1973), is not dispositive. Whether or not Blue Cross is considered to be "in the insurance business" for certain purposes, the challenged *activities* still constitute "the business of insurance." "The exemption is for the 'business of insurance,' not the 'business of insurers.'" *Royal Drug*, 440 U.S. at 211.

2. *Regulation by state law.* Turning to the second requirement for exemption under the Act, it is clear that both HealthMate and the adverse selection policy were "regulated by state law." The Rhode Island Department of Business Regulation approved the marketing of HealthMate, as well as the adverse selection rating formula. Ocean State protests that DBR did not approve the specific elements of HealthMate and adverse selection that Ocean State is challenging—for example, the decisions as to where and at what price to offer HealthMate, and the specific projections (which were plugged into the adverse selection formula) of the number of employees who would switch from standard Blue Cross to HMOs. In demanding this level of specificity, however, Ocean State misinterprets the provision of the Act that limits the exemption to conduct that is "regulated by State law." 15 U.S.C. § 1012(b). The Supreme Court has suggested that this requirement is satisfied by general standards set by the state. *See Federal Trade Commission v. National Casualty Co.*, 357 U.S. 560, 564-65 (1958). As the Fourth Circuit has put it more recently, "A body of state law which proscribes unfair insurance practices and provides for administrative supervision and enforcement satisfies the state regulation requirement of the exemption." *Mackey v. Nationwide Insurance Cos.*, 724 F.2d 419, 421 (4th Cir. 1984) (citing *FTC v. National Casualty Co.*).⁸

3. *"Boycott, coercion, or intimidation."* The McCarran-Ferguson Act specifically excepts from the ex-

⁸ Ocean State also argues that the adverse selection policy is not exempted by the McCarran-Ferguson Act because Blue Cross began using the adverse selection formula before state approval was obtained. *See note 2, supra.* But this lapse on Blue Cross's part has little bearing on whether the use of the adverse selection factors was "regulated by state law." It was precisely because of the presence of a comprehensive state regulatory system that DBR was able to order Blue Cross to suspend its use of the adverse selection formula, and Blue Cross did not resume its use until after DBR approval was obtained.

emption any "act of boycott, coercion, or intimidation." 15 U.S.C. § 1013(b). Ocean State argues in its reply brief that "the very purpose of the adverse selection factors was to coerce employers not to offer Ocean State or, failing that, at least to coerce employers into also offering HealthMate whenever Ocean State was offered." We do not believe, however, that this amounts to an allegation of "coercion" under the meaning of the Act.⁹ Although Blue Cross may have to lure employers and individual subscribers from Ocean State to HealthMate, Ocean State does not point to any evidence that any employer was *coerced* to offer HealthMate or not to offer Ocean State. Even the one personnel manager who testified that the adverse selection policy served to dissuade his company from offering Ocean State did not suggest that the policy left him no choice in the matter. He merely faced rate increases that were somewhat greater than they otherwise would have been.¹⁰

⁹ Much of the case law interpreting the provision focuses upon the "boycott" rather than the "coercion, or intimidation" aspect of the exception. *See, e.g., St. Paul Fire and Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978). Coercion has not generally been interpreted to include situations where options have not been entirely closed off to the allegedly coerced parties, even though such options may have been made more expensive. In *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir. 1983), *cert. denied*, 464 U.S. 822 (1984), for example, the requirement by a nonprofit provider of health insurance and health care services that its insureds use the provider's pharmacy to receive the pharmacy benefits under its policies did not amount to an attempt to boycott, coerce, or intimidate other pharmacies where the provider did not preclude its insurers from patronizing other pharmacies. *See also Feinstein v. Nettleship Co. of Los Angeles*, 714 F.2d 928 (9th Cir. 1983), *cert. denied*, 466 U.S. 972 (1984) (agreement between county medical association and medical malpractice insurers to offer malpractice insurance only to association members was not an agreement to boycott or coerce physicians to purchase carriers' insurance).

¹⁰ In any event, Ocean State has waived the coercion argument. At trial, although the district court declined to rule on whether

We conclude that the challenged actions of Blue Cross with respect to HealthMate and adverse selection are exempt from antitrust scrutiny under the McCarran-Ferguson Act.

C. *The Prudent Buyer Policy.*

The Prudent Buyer policy involves Blue Cross's relationships not with its subscribers but with its provider physicians. Blue Cross makes no claim that this policy is protected by the McCarran-Ferguson exemption. *Cf. Royal Drug.* 440 U.S. 205 (contracts between Blue Shield and participating pharmacies not exempted from antitrust scrutiny). We agree with the district court, however, that the Prudent Buyer policy—through which Blue Cross ensured that it would not pay a provider physician any more for any particular service than she was accepting from Ocean State or any other private health care purchaser—is, as a matter of law, not violative of section 2 of the Sherman Act.

Section 2 of the Sherman Act makes it unlawful to "monopolize . . . any part of the trade or commerce among the several states." 15 U.S.C. § 2. The offense of monopolization has two elements:

- (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.

Blue Cross's conduct was covered by the McCarran-Ferguson exemption, it did rule that the exception did not apply, noting that "[t]here's no evidence of boycott, intimidation or otherwise." Ocean State apparently objected to this ruling but failed to take exception to it in its initial brief on appeal. It made no argument that Blue Cross's conduct took the form of coercion within the meaning of the McCarran-Ferguson Act. Ocean State's resurrection of this argument in its reply brief comes too late.

United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966). On this appeal, Blue Cross does not dispute its monopoly power in the market for health care insurance in Rhode Island. Ocean State, for its part, concedes that Blue Cross acquired its historical advantages legitimately. The issue in dispute is whether Blue Cross *maintained* its monopoly position through improper means.

Section 2 does not prohibit vigorous competition on the part of a monopoly. To the contrary, the primary purpose of the antitrust laws is to encourage competition. *See, e.g., Standard Oil Co. v. Federal Trade Commission*, 340 U.S. 231, 248-49 (1951). What section 2 *does* prohibit is "exclusionary" conduct by a monopoly, often defined as "behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78 (1978), quoted by *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985). To decide whether the Prudent Buyer policy can reasonably be found to be exclusionary, we must ask whether Blue Cross's conduct "went beyond the needs of ordinary business dealings, beyond the ambit of ordinary business skill, and 'unnecessarily excluded competition'" from the health care insurance market. *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227, 230 (1st Cir. 1983) (citing *Greyhound Computer Corp. v. International Business Machines Corp.*, 559 F.2d 488, 498 (9th Cir. 1977), cert. denied, 434 U.S. 1040 (1978)).

In the case at hand, the record amply supports Blue Cross's view that Prudent Buyer was a bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services. According to the policy, when physicians provided data on the lowest prices they accepted for particular services, and these prices were lower than those allowed by Blue Cross, Blue Cross lowered its price to match the lowest price ac-

cepted. When Ocean State physicians did not provide this price information, Blue Cross reduced its fee to the physicians by 20%, to correspond to Ocean State's 20% withhold. Blue Cross estimated that it saved \$1,900,000 through this policy.

We agree with the district court that such a policy of insisting on a supplier's lowest price—assuming that the price is not “predatory” or below the supplier's incremental cost—tends to further competition on the merits and, as a matter of law, is not exclusionary. It is hard to disagree with the district court's view:

As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

Ocean State, 692 F. Supp. at 71.

This conclusion is also compelled by this court's holding in *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985) that a health insurer's unilateral decisions about the prices it will pay providers do not violate the Sherman Act—unless the prices are “predatory” or below incremental cost—even if the insurer is assumed to have monopoly power in the relevant market. *See id.* at 927.

Kartell concerned Blue Shield of Massachusetts's ban on balance billing, a price policy according to which Blue Shield paid participating physicians only if they agreed not to make any additional charges to the subscriber. We held that, for antitrust purposes, a health insurer like Blue Shield must be viewed “as itself the purchaser of the doctors' purchases.” *Id.* at 924. As such, the insurer—like any buyer of goods or services—is lawfully entitled to bargain with its provider for the best price it can get. *See id.* at 928. “[E]ven if the buyer has monopoly power, an antitrust court . . . will not interfere with a buyer's (nonpredatory) determina-

tion of price." *Id.* at 929. In the present case, Ocean State does not contend that the prices paid under the Prudent Buyer policy were "predatory" or below anyone's incremental costs. As Blue Cross argues, the legality of the Prudent Buyer policy rests *a fortiori* upon the holding in *Kartell*. In that case, Blue Shield sought to limit the fees to be charged by the physician to the subscriber; here, Blue Cross is limiting the price that *it* pays to the physician for services it is purchasing.

Ocean State argues that *Kartell* is a "vertical" case (involving the effects of Blue Shield's policy on its provider physicians), while the present case is "horizontal" (involving the effects of Blue Cross's policy on its competitor, Ocean State). But the distinction is of no consequence. In both cases the challenged activity is the price that the buyer offers to the seller. Moreover, in *Kartell* the physician plaintiffs contended that Blue Shield's balance billing ban was anticompetitive horizontally as well as vertically. The physicians argued that Blue Shield's pricing policy enabled it to attract more subscribers, thus "increasing its dominance in the health insurance business." *Id.* at 929. We rejected this argument, noting that it "comes down to saying that Blue Shield can attract more subscribers because it can charge them less." *Id.* at 930. Such an outcome—more business at lower prices—would not ordinarily run afoul of the antitrust laws.¹¹ Citing a case that centered on an allegation of injury by a horizontal competitor, we concluded that "Blue Shield seems simply to be acting 'as every rational enterprise does, *i.e.*, [to] get the best deal possible.'" *Id.* at 929-30 (quoting *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3d Cir.), cert. denied, 414 U.S. 1093 (1973)).

¹¹ In the present case, Ocean State alleges that Blue Cross never actually passed along its savings to subscribers. But nothing turns on whether Blue Cross in fact lowered its rates. The fact remains that achieving lower costs is a legitimate business justification under the antitrust laws.

In *Kartell* we cited several additional reasons why an antitrust court should hesitate to invalidate the Blue Shield-physician price bargain. Noting that the prices at issue were *low* prices, not high prices, we observed that "courts . . . should be . . . reluctant to condemn too speedily . . . an arrangement that, on its face, appears to bring low price benefits to the consumer." *Id.* at 930-31 (citing *Barry Wright*, 724 F.2d at 231-34). We also expressed the view that courts should be reluctant to interfere in the domain of medical costs, "an area of great complexity where more than solely economic values are at stake." *Id.* at 931. Both of these considerations are relevant to the present case as well.

In one sentence of its opinion awarding judgment notwithstanding the verdict to Blue Cross, the district court stated that the same standards of anticompetitive conduct should apply to all market participants, regardless of their degree of market power: "There is no principle of antitrust law which would deny a business practice to any entity with market power and permit that practice on the part of a competitor who does not have market power." *Ocean State*, 692 F. Supp. at 71. Ocean State correctly observes that this sentence misstates the law. In fact, the definition of "exclusionary" conduct cited above, *supra* at 22, leaves open the possibility that certain "conduct is illegal when taken by a monopolist because it tends to destroy competition, although in the hands of a smaller market participant it might be considered harmless, or even 'honestly industrial.'" *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 274-75 (2d Cir. 1979) (citation omitted), *cert. denied*, 444 U.S. 1093 (1980). But the district court's ultimate judgment remains correct in this case, notwithstanding this misstatement. Even a monopoly can engage in a competitive course of conduct, so long as it does so for valid business reasons (such as the desire to get the lowest possible price), rather than in order to smother competition. *Compare*

Aspen Skiing, 472 U.S. at 608 (the jury's conclusion that a monopolist's conduct was exclusionary "is strongly supported by Ski Co.'s failure to offer any efficiency justification whatever for its . . . conduct") with the present case (in which the efficiency justification—lower costs—is evident).

Even if we assume that the Prudent Buyer policy, as written is legitimate, Ocean State argues that Blue Cross applied the policy in a way that was in fact directed at the illegitimate goal of destroying Ocean State, rather than at the legitimate goal of lowering costs. But we do not believe that the evidence, even when viewed in the light most favorable to Ocean State, supports this contention.

First, Ocean State contends that although the Prudent Buyer policy was neutral on its face, Blue Cross in fact applied it only to Ocean State physicians. But even if we assume for argument's sake that Blue Cross selectively applied Prudent Buyer in this way, its conduct remains legitimate. It was primarily Ocean State physicians who were selling their services at a lower price to another provider (Ocean State) than to Blue Cross. Indeed, it was Ocean State's lower pricing policy—in particular, its 1986 decision not to return its participating physicians' withhold for 1985—that gave rise to Prudent Buyer. Therefore, it seems only logical—and not illegitimate—for Blue Cross to have focused its efforts in applying Prudent Buyer on Ocean State physicians.

Second, Ocean State argues that Blue Cross initially applied its policy to Ocean State physicians even before it knew whether Ocean State would return the 20 percent withhold for 1986 to its physicians. This left open the possibility that Blue Cross, by reducing its payments to Ocean State physicians by 20 percent, would actually be paying *less* than Ocean State. But even if we assume

that these contentions are borne out by the record, we see nothing wrong with this conduct. Blue Cross offered to Ocean State physicians payment schedules that matched what they were *currently* accepting from Ocean State. The antitrust laws do not prevent a purchaser from making such an obviously reasonable and obtainable price bargain with a provider.

Third, Ocean State suggests that Blue Cross applied Prudent Buyer in a way that bribed some physicians into promising to resign from Ocean State. Ocean State contends that Blue Cross "exempt[ed] from Prudent Buyer some physicians who missed the Ocean State contractual cutoff date, and hence were automatically renewed for a year, if they pledged to drop out of Ocean State in the next year." The record does not support this allegation, however. The only evidence pointed to by Ocean State in support of this charge is the testimony of Thomas Aman, head of Blue Cross's professional relations department, that he had made such a promise to one podiatrist. Aman testified that he had thought the policy allowed for such an exemption, but then discovered that he had been mistaken. The evidence of a single instance of the misapplication of the Prudent Buyer policy is not enough to support the claim that the policy was used in an exclusionary way. Strikingly, not a single Ocean State physician testified that Blue Cross directly encouraged him or her to resign from Ocean State.¹²

¹² Ocean State likens Blue Cross's conduct to the efforts of the A & P company, found to be illegal in *United States v. New York Great Atlantic & Pacific Tea Co.*, 173 F.2d 79 (7th Cir. 1949), "to exert pressure on suppliers either not to deal or to alter their dealings with A & P's competitors" (as summarized in *Travelers Insurance*, 481 F.2d at 85). We find the resemblance to be slight. A & P's pressure on suppliers included a refusal to buy from suppliers who sold to anyone else through brokers. This, in turn, closed out competitors—presumably including smaller groceries—who were

Finally, Ocean State points to evidence in the record that Blue Cross officials *hoped* that Prudent Buyer—together with HealthMate and adverse selection—would have the effect of destroying or weakening Ocean State. For example, there was testimony that Blue Cross's president had expressed—in none-too-polite terms—a desire to emasculate Ocean State. Another Blue Cross executive wrote in a handwritten note that “not one guy *in the state isn't going* to know the implication of signing with Ocean State” (emphasis in original). The jury may reasonably have concluded, on the basis of this and other evidence, that Blue Cross's leadership desired to put Ocean State out of business. But the desire to crush a competitor, standing alone, is insufficient to make out a violation of the antitrust laws. As this court has noted, “‘intent to harm’ without more offers too vague a standard in a world where executives may think no further than ‘Let's get more business,’ and long-term effects on consumers depend in large measure on competitors' responses.” *Barry Wright*, 724 F.2d at 232. As long as Blue Cross's course of conduct was itself legitimate, the fact that some of its executives hoped to see Ocean State disappear is irrelevant. Under these circumstances Blue Cross is no more guilty of an antitrust violation than a boxer who delivers a perfectly legal punch—*hoping* that it will kill his opponent—is guilty of attempted murder.

We conclude that the Prudent Buyer policy did not as a matter of law violate section 2 of the Sherman Act. The district court's judgment notwithstanding the verdict is therefore affirmed. Because we hold that Prudent Buyer does not violate the antitrust laws, we also affirm the district court's refusal to enjoin the continued use of this policy.

unable to buy directly from suppliers. *See A & P*, 173 F.2d at 83. In contrast, there is no evidence that Blue Cross refused to deal with Ocean State physicians, or that it pressured Ocean State physicians to alter their dealings with Ocean State.

V. THE CLAIM OF TORTIOUS INTERFERENCE WITH CONTRACTUAL RELATIONSHIPS

We also conclude that the district court was correct in granting judgment notwithstanding the verdict on Ocean State's pendent state tort claim of intentional interference with contractual relationships. Ocean State alleged that Blue Cross's conduct "interfere[d] with existing contractual relationships between Ocean State and Class Members." This claim seems to relate only to the Prudent Buyer policy, which is the only one of the challenged Blue Cross practices that directly concerns Ocean State's relationships with the class members, its participating physicians. The district court charged the jury, without objection, on this limited theory.

To establish a claim for tortious interference with a contractual relationship under Rhode Island common law, the plaintiff must show "(1) the existence of a contract; (2) the alleged wrongdoer's knowledge of the contract; (3) his intentional interference; and (4) damages resulting therefrom." *Smith Development Corp. v. Bilow Enterprises*, 112 R.I. 203, 211, 308 A.2d 477, 482 (1973). Blue Cross may defend against a claim of tortious interference on the ground that any interference was *justified*. See *id.*; *Mesolella v. City of Providence*, 508 A.2d 661, 670 (R.I. 1986). Conduct in furtherance of business competition is generally held to justify interference with others' contracts, so long as the conduct involves neither "wrongful means" nor "unlawful restraint of trade." *Restatement (Second) of Torts* § 768 at 39 (1979). We are left to decide whether Prudent Buyer could have been found to be "wrongful" under Rhode Island law.

The district court correctly—and without objection— instructed the jury on the law with respect to justification:

A Defendant's conduct does not constitute intentional interference with a contract if it is justified.

As you have been instructed the law favors vigorous competition. Conduct is justified if it is action taken in legitimate competitive business activity. Competition means that a competitor will of necessity interfere with its competition. Thus the fact of interference is justified. It is only if the competitor uses methods of competition which are beyond those which competitors must expect to occur in the marketplace, that is, by competition which is based upon illegal [or] illegitimate means that you may find that any competitive action is unjustified.

Despite the jury's finding of liability, we hold that the Prudent Buyer policy was justified as a matter of law. As we have shown, Blue Cross's conduct was legitimate competitive activity that was not "illegal" under the antitrust laws. By the same token, and for essentially the same reasons, the conduct was not "wrongful" or "tortious" under state law. To be sure, not all business torts are "exclusionary" under the antitrust laws. *See* 3 P. Areeda & D. Turner, *Antitrust Law* §§ 626d, 737b, 7381 (1978). In an appropriate case, a plaintiff might fail to establish an antitrust violation but still establish that certain torts had been committed. *See, e.g., Kartell*, 749 F.2d at 933-34 (noting the possibility that Blue Shield's conduct in that case, though not in violation of the Sherman Act, "might amount to minor business torts"). In the present case, however, Ocean State fails to allege any tortious activity other than precisely the same "anticompetitive" behavior alleged in its antitrust claim. Ocean State puts the matter this way in its brief:

The evidence concerning interference with contract largely overlaps that addressed to the antitrust count (see pp. 5-26, *supra*). Without unduly repeating ourselves, we note that there was varied and significant evidence from which the jury was able to find that Blue Cross acted anticompetitively

to harm Ocean State and the physician class rather than merely to adapt reasonably to competitive pressures.

Under these circumstances, the antitrust law provides the best available barometer—indeed the only available barometer—of whether or not Blue Cross's conduct can be found to be “wrongful” or “illegitimate”—and, hence, tortious. No other relevant tort standards have been called to our attention in the case law or otherwise. For the same reasons that we held that Prudent Buyer did not violate the Sherman Act, therefore, we hold that it could not as a matter of law constitute tortious interference with plaintiffs' contractual relationships. Accordingly, we affirm the district court's judgment notwithstanding the verdict on the tortious interference claim and we deny Ocean State's motion for an additur to the jury award to the physician class.

VI. CONCLUSION

For the reasons stated above, we affirm the district court's award of judgment notwithstanding the verdict to Blue Cross on both the Sherman Act and the tortious interference claims. We also deny Ocean State's motions for an injunction and for an additur in favor of the physician class.

Affirmed.

APPENDIX B

**UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT**

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs-Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

JUDGMENT

Entered: August 21, 1989

This cause came on to be heard on appeal from the United States District Court for the District of Rhode Island, and was argued by counsel.

Upon consideration whereof, It is now here ordered, adjudged and decreed as follows: The judgment of the District Court is affirmed.

By the Court:

/s/ [Illegible]
Clerk

cc:
Messrs. Gerson and Snow

APPENDIX C

UNITED STATES DISTRICT COURT.
D. RHODE ISLAND

Civ. A. No. 86-0598-B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant.

July 27, 1988

Thomas A. Lynch, Lynch and Greenfield, Providence, R.I., William B. Kopit, Mark E. Lutes, Stuart Gerson, Epstein, Becker, Borsody & Green, P.C., Washington, D.C., for plaintiffs.

Patrick Quinlan, Quinn, Shectman & Teverow, Julius C. Michaelson, Providence, R.I., for plaintiff-intervenors.

Steven E. Snow, James Purcell, Partridge, Snow & Hahn, Providence, R.I., for defendant.

OPINION

FRANCIS J. BOYLE, Chief Judge.

STATEMENT OF FACTS

Defendant, Blue Cross & Blue Shield of Rhode Island, had been charged by Plaintiffs with restraint of trade and monopolization in violation of both federal and state law. After trial, a jury awarded Plaintiffs compensatory damages in the total amount of \$2,693,437 and punitive

damages in the amount of \$250,000 for wrongful interference with contractual relationships, and found that Blue Cross & Blue Shield of Rhode Island was guilty of monopolization but awarded it no damages. Now pending are the Defendant's motion for judgment notwithstanding the verdict on the antitrust and tortious interference with contractual relationships claims. In the alternative, the Defendant seeks a new trial only on the interference with contractual relationships claims and not on the antitrust claims. Plaintiffs seek injunctive relief and an additur on the antitrust claims. In addition, the Defendant filed a counterclaim against the Plaintiff-Intervenors, the Physicians and Surgeons Association of Rhode Island, Inc. and thirteen individual members of the class, to prevent the Plaintiff-Intervenors from collectively negotiating fees with Blue Cross.¹

Plaintiffs claimed that the Defendant violated Sections One and Two of the Sherman Antitrust Act, 15 U.S.C. §§ 1, 2 (Supp. 1986), violated the analogous Rhode Island Antitrust Statutes, R.I.Gen.Laws § 6-36-1 to 26 (Supp.1985), and breached the common law duty not to wrongfully interfere with contractual relationships. The Plaintiff Ocean State Physicians Health Plan, Inc. and the Plaintiff class of physicians sought monetary damages against the Defendant due to Blue Cross's business programs which for short hand purpose of reference are called prudent buyer, adverse selection, and HealthMate. Plaintiffs claimed that those programs were unlawful. Plaintiffs sought a permanent injunction prohibiting De-

¹ The Physicians and Surgeons Association of Rhode Island and nineteen individual physicians intervened seeking injunctive relief and monetary damages against Defendant Blue Cross, a claim dismissed at trial. The Defendant Blue Cross also claimed against the Plaintiff-Intervenors alleging that Plaintiff-Intervenors violated Section One of the Sherman Act by conspiring to collectively negotiate with Blue Cross and sought injunctive and declaratory relief. There is no present threat to negotiate; therefore, the claim is denied as premature.

fendant from using its prudent buyer and HealthMate programs.

THE PARTIES

The Plaintiffs, Ocean State Physicians Health Plan, Inc. (Ocean State) and Anthony J. Kazlauskas and Jeffrey C. Winters, on behalf of the class of physicians, commenced suit against the Defendant Blue Cross & Blue Shield in September 1986. The class of physicians was defined by a court order dated April 2, 1987 to include "all physicians who contract with Ocean State to provide physicians services and who are also reimbursed by Blue Cross & Blue Shield of Rhode Island for the provision of physician services to defendant's subscribers." The Defendant, Blue Cross & Blue Shield of Rhode Island, is a nonprofit hospital and medical services corporation which provides insurance for hospital and medical expenses.

Ocean State is a health maintenance organization (HMO) with headquarters in Warwick, Rhode Island. As an independent practice association type HMO, Ocean State contracts with physicians to provide medical care to its subscribers; Ocean State then pays its contracted physicians on a fee for service basis. Initially, subscribers paid little or no additional cost other than the premium paid to the HMO. The physicians' practice remained independent from the HMO.

In 1980, Ocean State submitted its license application to the Rhode Island Department of Health. It began operation by offering hospital and physicians costs coverage to employee groups of twenty-five or more. Originally, Medserco, a St. Louis based company managed Ocean State. Presently, United HealthCare, a Minnesota based company, manages Ocean State and is its single principal shareholder owning 20% of the stock. The remaining 80% of shares are held by some of the physicians who provide services to Ocean State subscribers. New Ocean State participating physicians pay up to

\$1,000 to contract with Ocean State to provide health services to Ocean State subscribers.

Ocean State is a federally qualified HMO. It determines its rates based on a community rating method. 42 U.S.C. Section 300e-1(8) provides that an HMO may choose to group by individual or family but within the chosen group, rates are to be equal subject to adjustment factors, such as age and sex. State law permits Blue Cross & Blue Shield to base its premiums for employer groups on the prior actual experience of each particular insured group.

FACTUAL BACKGROUND—PROCEDURAL

In April 1987, the Court granted Plaintiff Winters' and Kazlauskas' motion for class certification after the Defendant failed to object. The class, as noted, included all physicians who contract with Ocean State and who are also reimbursed by Blue Cross & Blue Shield. It was estimated that 900 physicians were certified as members of the class.

Although in their original complaint Plaintiffs did not request a jury trial, they subsequently demanded a jury trial. At the conclusion of Plaintiffs' case, the Court granted the Defendant's motion for a directed verdict on all claims under Section One of the Sherman Act against Ocean State and the class of physicians. The Court also granted Blue Cross & Blue Shield's motion for a directed verdict against the Plaintiff-Intervenors. At the conclusion of the case, the jury returned a verdict finding Blue Cross & Blue Shield liable to both Ocean State and the class of physicians on the Section Two antitrust claims. The jury, however, awarded no damages. On the claim of tortious interference with contractual relationships, the jury found Blue Cross & Blue Shield liable to Ocean State and awarded compensatory damages of \$947,000 and punitive damages of \$250,000. The jury also found

Blue Cross & Blue Shield liable to the class of physicians on the interference with contractual relationships claim and awarded \$1,746,437 in compensatory damages.

Pending before the Court are both equitable and legal claims. Plaintiffs move for a permanent injunction against prudent buyer and HealthMate. In addition, they seek an additur to the class of physicians on the antitrust claim. Defendant moves for a judgment notwithstanding the verdict on the antitrust claims and intentional interference with contractual relationships claims. In the alternative, the Defendant seeks a new trial on the claims of interference with contractual relationships.

FACTUAL BACKGROUND

For many years Blue Cross of Rhode Island and Blue Shield of Rhode Island were the unchallenged leading health care financing organizations in Rhode Island. Blue Cross of Rhode Island was incorporated in the 1930's as a non-profit hospital service corporation that provided insurance coverage for hospital services. Blue Shield of Rhode Island was incorporated later and limited its insurance coverage to payment of physician charges. Blue Cross of Rhode Island and Blue Shield maintained separate Boards of Directors, reserves, and auditing of financial statements.

Under an administrative services agreement, however, Blue Cross provided management and staff for Blue Shield. Usually Blue Cross and Blue Shield policies were marketed together as a package to employers. Occasionally, an employer could purchase Blue Cross coverage alone, but employees were not permitted to purchase only Blue Shield coverage. Neither Blue Cross nor Blue Shield were marketed with other health insurance.

In 1971, Rhode Island Group Health Association (RIGHA) a group model Health Maintenance Organiza-

tion (HMO) entered the Rhode Island health care financing market. A group model HMO employs physicians to serve the medical needs of its subscribers. Services are usually provided at a fixed location and this was initially true of RIGHA. RIGHA had little impact on Blue Cross & Blue Shield's share of the market. RIGHA entered into an agreement with Blue Cross & Blue Shield whereby RIGHA would purchase hospital services through Blue Cross. Thus, RIGHA enjoyed Blue Cross & Blue Shield hospital discounts; while Blue Cross & Blue Shield benefited because they then claimed RIGHA subscribers within their membership and thereby increased their claimed size of the market. As a result, Blue Cross was further able to negotiate favorable agreements for the cost of hospital care.

In addition, RIGHA entered into a joint marketing agreement with Blue Cross & Blue Shield to coordinate marketing activities. Both agreements were terminated in March 1982, after a newspaper article disclosed the arrangement. There was testimony, however, that the sharing of hospital and physician discounts continued through May 1986.

In 1980 at the time Ocean State applied to the Rhode Island Department of Health for licensing as an HMO, Blue Cross & Blue Shield continued to dominate the health care financing market. Blue Cross & Blue Shield controlled a very large percentage of the market. Competition from other health care financing insurers was virtually non-existent. RIGHA was then the only licensed HMO in Rhode Island and its market share was minimal.

Although Blue Cross & Blue Shield researched the financial background of Medserco, Ocean State's original management company, and considered using that information to discredit Ocean State's regulatory application, it did not do so. Blue Cross and Blue Shield took an active interest in Ocean State's licensing procedure, but

did not oppose the application. Subsequently Ocean States application was approved.

At about the same time Blue Cross and Blue Shield were negotiating a merger. In 1982, after two years of negotiations the two companies merged to form one corporation, Blue Cross & Blue Shield of Rhode Island, [hereinafter Blue Cross & Blue Shield] which provided both hospital and physician insurance coverage. One Board of Directors and one Chief Executive Officer managed the new corporation.

In addition, the General Assembly of the State of Rhode Island enacted the Health Maintenance Organization Act of 1983, R.I. Gen.Laws §§ 27-41-1 *et seq.* (Supp. 1986), which was modeled after the federal HMO Act, 42 U.S.C. § 300e-9 (Supp.1986). Rhode Island is unique in the large percentage of employees covered by employer provided health plans. The State Act incorporates a dual choice provision which requires employers to offer a licensed qualified HMO as an employee choice for health insurance if an HMO provides services in the area where the employee resides. Blue Cross & Blue Shield challenged this dual choice provision as inconsistent with provisions of the federal Employee Retirement Income Security Act (ERISA). See 29 U.S.C. §§ 1001-1461 (Supp.1987). In *Blue Cross of R.I. v. Cannon*, 589 F.Supp. 1483 (D.R.I. 1984), the suit was dismissed because it was not ripe; however, it was noted that the employer's obligation to provide an HMO alternative is subject to the condition precedent of a request by an eligible HMO to be included in the health insurance offering.

As of the Spring 1986, Blue Cross & Blue Shield was faced with a serious competitive problem. While Blue Cross & Blue Shield lost approximately 30,000 of its 543,015 enrollees; Ocean State's enrollment exceeded the most optimistic expectations and had grown to 70,000. Blue Cross & Blue Shield's loss of enrollment was attributed to its increased premium rates and to its lack

of an HMO plan which would provide more coverage than traditional Blue Cross & Blue Shield.

Rates had to be increased because Blue Cross & Blue Shield was experiencing financial difficulties. Its cash reserves had dropped below the State law requirement, which requires Blue Cross & Blue Shield to maintain an available cash supply sufficient to pay all operating expenses and claims for not less than a 1½ month period. *See R.I.Gen.Laws § 27-19-6 (Supp.1986).* Payments of claims exceeded Blue Cross & Blue Shield's estimates and the amount of revenue generated through premiums was not sufficient to cover Blue Cross & Blue Shield's anticipated costs. Blue Cross & Blue Shield had to raise its premium rates. The increased rates further contributed to its loss of enrollment which further required higher rates to cover the losses due to enrollees dropping out.

Although Blue Cross & Blue Shield dominated the health care financing industry, the loss of enrollment created concern. There was conflicting testimony at trial about Blue Cross & Blue Shield's market share.

Plaintiffs claimed that Blue Cross & Blue Shield controlled 80% of the market. Defendant did not dispute that it was the largest health care cost insurer in Rhode Island, but would not agree that it controlled 80% of the market. Ocean State claimed that 656,650 persons in Rhode Island were eligible to procure private health coverage and that 543,015 persons selected Blue Cross & Blue Shield coverage. Therefore, according to Plaintiffs' calculations Blue Cross & Blue Shield's enrollment share was 82.7%.

Defendant downwardly adjusted this estimate of its market share by making three adjustments to the market share calculation. First, the estimated number of members covered under a family contract was reduced from 3.4 persons to 2.8 persons, which resulted in a 17.64% reduction of Blue Cross & Blue Shield's enrollment share.

Next, duplicate coverage was factored into the calculation. The Defendant had assumed that 12% of Blue Cross & Blue Shield's enrollees had duplicate coverage with another Blue Cross & Blue Shield plan and that 8% of Blue Cross & Blue Shield's enrollees had duplicate coverage with another company. Thus, adjustments to the market reduced Blue Cross & Blue Shield's market share to 62.8%. Finally, Blue Cross & Blue Shield assumed the Rhode Island employment base was 10% greater than reflected in the Rhode Island population count because more workers came into the State to work than left the State to work. So Blue Cross & Blue Shield estimated that the total population eligible to select Blue Cross & Blue Shield coverage was 722,315 persons (the Rhode Island population 656,650 + the non-state resident workers 65,665). With the foregoing adjustments, Blue Cross & Blue Shield's market share was 57.1%. The Defendant, although it disputed the Ocean State estimate of Blue Cross & Blue Shield's market share, agreed that it had a substantial share of the market. This was an admission of the obvious. Blue Cross & Blue Shield is clearly the major provider of private health care cost payment in Rhode Island and thus it is the major factor in the competitive market. It clearly had market power. The issue here is whether or not it exercised that power unlawfully.

Both Blue Cross & Blue Shield and Ocean State were experiencing financial problems at about the same time during the Spring and Summer of 1986. Blue Cross & Blue Shield was facing enrollment losses and increased premiums; while Ocean State's operating costs were exceeding its income. Both Ocean State and Blue Cross & Blue Shield had to make changes and adopt new programs. Blue Cross & Blue Shield responded with the prudent buyer policy, adverse selection, and HealthMate. Ocean State went through a major reorganization, increased the amount of payment subscribers were required

to pay for services rendered, and created a program called Specialty Incentive Pools (SIPS).

In May 1986, the Blue Cross & Blue Shield's Board of Directors approved a three prong approach to deal with Blue Cross & Blue Shield's loss of enrollment and financial difficulties. The plan included (1) implementing the "prudent buyer policy," (2) instituting "adverse selection rating factors" and (3) marketing of a new product, which was ultimately called "HealthMate." Blue Cross & Blue Shield submitted a series of riders to the classic hospital and medical service plans to the Department of Business Regulations (DBR), State of Rhode Island for its approval. The DBR approved the new HealthMate product, which was known as the "Z Plan," "Maps Plus," and 'Plan 100 Plus.' HealthMate provided 15% more coverage than standard Blue Cross & Blue Shield. It included hospital and medical service plans plus other coverage such as office visits, prescription drugs, student rates, and 'good health' benefits. Under HealthMate, subscribers must use participating physicians otherwise the plan would not pay for physician services. In addition, all Blue Cross & Blue Shield participating physicians are required to provide services under HealthMate and to accept the HealthMate payment as payment in full if they wished to remain Blue Cross & Blue Shield participating physicians.

HealthMate was first offered to employees of the State of Rhode Island in July 1986. This is the largest single group of employees covered by an employer health plan in Rhode Island, and no doubt, that fact prompted the creation of HealthMate. The Department of Administration, the State agency which awarded contracts for health coverage, extended its open enrollment season for selecting a health plan so that HealthMate could be offered. Later, HealthMate was offered to other experience rated groups. HealthMate was never offered alone as a health insurance plan, but was only marketed as an alternative

to traditional Blue Cross & Blue Shield if a competing HMO was also being considered as a health insurance option. Today, HealthMate is offered to all employer groups with more than 50 employees.

HealthMate was marketed with financial incentives for employers. If the employer paid the full cost of its employees' health insurance, HealthMate was offered at the same rates as traditional Blue Cross & Blue Shield. If employees were required to contribute to their coverage, then HealthMate was offered at 5% below the cost of traditional Blue Cross & Blue Shield. Ocean State claimed that between June 1986 and August 1987, it lost profits of \$58,550 because of the head to head marketing and low cost of HealthMate. In addition, Ocean State estimated a \$59,041 future loss of profits through June 1988.

To support the tiered pricing for HealthMate and traditional Blue Cross & Blue Shield coverage, Blue Cross & Blue Shield approved an adverse selection policy on June 1, 1986. Blue Cross & Blue Shield implemented the adverse selection policy without approval from the Department of Business Regulation (DBR). In October 1986, DBR ordered Blue Cross to cease using the adverse selection policy until it obtained DBR approval. On November 12, 1986, the DBR approved the adverse selection factors and Blue Cross resumed use of the adverse selection policy.

Blue Cross & Blue Shield was concerned that it would be adversely selected by subscribers if other health plans were offered. "Adverse selection" is jargon which means exactly the opposite of what it says. It has nothing to do with selection of Blue Cross. It is the opposite, the selection of a competitor by a Blue Cross subscriber. It means that Blue Cross & Blue Shield was concerned that it would lose its best (least expensive) members. It was concerned that it would lose a large percentage of its younger healthier subscribers to a different company

with a more comprehensive preventive health plan and be left with an older, less healthy population, causing its claims costs per subscriber to increase. Thus to reflect this possible increase in cost per subscriber, adverse selection factors were applied.

Under the adverse selection policy, employers were offered three different rates for Blue Cross & Blue Shield indemnity coverage. Employers would be charged the lowest rate if the employer only offered traditional Blue Cross & Blue Shield coverage. If the employer offered traditional Blue Cross & Blue Shield, a competing HMO and HealthMate, then the rate for traditional Blue Cross & Blue Shield would be at a middle level. If an employer offered traditional Blue Cross & Blue Shield and a competing HMO but refused to offer HealthMate, then the highest rate for traditional Blue Cross & Blue shield coverage would be charged.

Adverse selection rate differentials were determined based on a formula which Blue Cross & Blue Shield designed. The formula incorporated two estimates. The first estimate was called the health factor, which concluded that HMO enrollees, on the average, would be 22% healthier (22% less expensive) than the aggregate membership of the employed group.

The second estimate in the adverse selection calculation was Blue Cross & Blue Shield's estimate of the number of subscribers that might enroll in competitive health plans. The estimate was not based on Blue Cross & Blue Shield's prior experience of subscribers switching health coverage but on Blue Cross & Blue Shield's projection. Ocean State contended that Blue Cross & Blue Shield overestimated the number of subscribers who would be lost to competing HMOs, causing the adverse selection calculation to be higher than what was necessary to ensure that its premiums reflected its costs.

In February 1987, the Department of Business Regulations (DBR) released a study of the number of Blue

Cross & Blue Shield enrollees that switched to HMOs. It found that fewer enrollees dropped traditional Blue Cross & Blue Shield coverage and replaced it with HMO coverage than Blue Cross & Blue Shield had projected. Many employers complained to DBR about the substantial increase in their premiums, partly due to the adverse selection factors, and they threatened to discontinue Blue Cross & Blue Shield coverage. In February 1987, Blue Cross & Blue Shield decided to base its calculation of losses to competing HMOs upon actual lost enrollment. Thus, the second estimate factor in the adverse selection calculation was adjusted as of February 1987.

Ocean State asserted that the overestimate of loss of subscribers to competing HMO artificially increased price differential which discouraged employers from offering a competing HMO, such as Ocean State. Furthermore, Ocean State claimed that the rate differentials were designed to discourage employers from offering competing health insurance options, or alternatively to force employers to offer HealthMate if a competing health plan was an option.

Meanwhile, the financial circumstances of Ocean State were also under stress. As a new HMO, Ocean State decided in 1983 that it would withhold 20% of the physicians' fee until the end of the year at which time if Ocean State's operational expenses were in the black then the withholding would be paid to the physicians. This was seen as an incentive to its contracted physicians to keep health care costs low. In 1984 Ocean State returned the withhold to physicians. In 1985, however, Ocean State retained the withhold because cost of operating exceeded Ocean State's estimates. This action occurred in 1986.

Ocean State memberships had risen astronomically, but the rate of increase began to level off. In the spring and summer of 1986, it began to experience financial concerns not different from those of Blue Cross & Blue

Shield. Ocean State initiated a drastic management change on July 1, 1986, and designed new incentives for physicians to maintain costs. Not coincidentally, these initiatives were roughly coincident with Blue Cross's trilogy of programs, HealthMate, adverse selection and prudent buyer.

In an effort to control expenses and hopefully to provide a dividend to its physician members, Ocean State implemented the Speciality Incentive Pools (SIPs) as of November 1, 1986. Speciality Incentive Pools is another instance of jargon. It simply means that the physician would be paid his or her full charge rather than only 80% of the charge, if there was enough money left in the pool at the end of the year to do so. Ocean State divided participating physicians into specialty categories. Each specialty was allotted a certain sum of money as its operating budget. Physicians were paid 80% of their charges. If expenses for the specialty category did not exceed estimated operational cost, then the remaining funds in the specialty category would be divided among physicians in that group. Each specialty group had a very good reason to provide services at the lowest cost; thus, the name Speciality Incentive Pools. The 1986 operational cost exceeded Ocean State's estimates. Therefore, nothing additional was paid to participating physicians through the Speciality Incentive Pools.

Blue Cross & Blue Shield expressed concern that physicians were giving greater discounts to Ocean State than to Blue Cross & Blue Shield. In response to the March 25, 1986, decision of Ocean State to retain the 1985 withholdings, Blue Cross & Blue Shield announced the prudent buyer policy on June 6, 1986. The policy, however, did not become effective until November 1, 1986.

Prudent buyer is more jargon. What it means is that Blue Cross & Blue Shield would not pay more to a physician than what the physician was willing to accept for performing the same services for another health care

cost provider, including Ocean State. Thus, if physicians were accepting 80% of their charges as payment in full from Ocean State, then Blue Cross would also pay only 80% of physicians charges, as payment in full. Plaintiffs asserted that the prudent buyer policy was fashioned after Blue Cross & Blue Shield's hospital participation policy. Under that policy Blue Cross & Blue Shield participating hospitals who offered competitors discounts, which were comparable or better than the approximate 13% discount provided Blue Cross & Blue Shield, were threatened with termination of their status as participating providers. The hospital participation policy had been successfully implemented and permitted Blue Cross to buy hospital services at the lowest rate.

Under the prudent buyer policy, Blue Cross & Blue Shield would not pay more for physician services than the lowest payment the physician accepted for such services. At trial Blue Cross & Blue Shield contended that it was only trying to get the best price for its subscribers. Blue Cross & Blue Shield required physicians to document that the fees the physicians charged Blue Cross & Blue Shield were the lowest that the physicians charged for that particular service. If a physician failed to document by September 15, 1986 that he or she was not charging Blue Cross & Blue Shield more than he or she was charging its competitors, then Blue Cross & Blue Shield reduced its reimbursement to the physician by 20%. There was evidence that Blue Cross & Blue Shield understood the ramifications of the prudent buyer policy. A handwritten note by a Blue Cross & Blue Shield management employee stated that "not one guy in the state isn't going to know the implication of signing with Ocean State." Plaintiffs made much of this observation.

Plaintiffs contended that approximately one-third of Ocean State's participating physicians resigned from Ocean State as a result of the prudent buyer policy. Testimony was, however, that physicians resigned for many reasons. Some physicians claimed they resigned

because they were concerned about the effect of the prudent buyer policy upon their Blue Cross & Blue Shield patients. Others claimed that they could not afford to have their Blue Cross & Blue Shield payments cut by 20%. It is clear that some physicians resigned from Ocean State because of the prudent buyer policy, but is also abundantly clear that the actual number was far less than that contended by Ocean State.

Because about 350 of its 1200 participating physicians resigned, Ocean States claimed that it had to pay for the services of more non-participating physicians in order to provide physician services to its members at a level comparable to the level which existed before the physicians resigned. Although the physicians resignations represented a cross section of specialties, Ocean State contended that certain specialties were harder hit, such as cardiac surgery. Thus, Ocean State had to buy more services from non-participating physicians, which was more expensive. As a result, Ocean State contended that it incurred greater cost for providing physician services to subscribers. Therefore, Ocean State claimed that due to the prudent buyer policy, it had to pay an additional \$946,260 to non-participating physicians between January 1987 and March 1987.

In addition, Ocean State contended that the reduction of participating physicians caused a reduction of subscribers. There was testimony that some subscribers dropped Ocean State when their personal physicians resigned from Ocean State. Ocean State would not pay the physician for services rendered to the patient and the patient would have to pay the physician without reimbursement from Ocean State. Ocean State claimed it lost \$597,016 in profits on enrolled members who dropped Ocean State between November 1986 and August 1987.

Ocean State presented evidence that under the prudent buyer policy, Blue Cross & Blue Shield withheld more than \$1,900,000 from Ocean State's 1200 participating

physicians. The certified class, however, included an estimated 900 physicians. During the time between implementation of the prudent buyer policy and the class certification, more than 300 physicians resigned from Ocean State. Those physicians who had prudent buyer withholds but were not participating physicians of Ocean State in April 1987 did not meet the definition of the class certification. The certified class of physicians claimed Blue Cross & Blue Shield withheld \$1,425,000 from it.

Blue Cross & Blue Shield acknowledged that under the prudent buyer policy between January 1, 1987 and May 30, 1987 it withheld \$2,058,169.58. During this period, providers requested \$682,351.36 in refunds. Blue Cross & Blue Shield estimated that the refund payments would be \$136,470.27 per month. Blue Cross & Blue Shield estimated that it would withhold \$2,838,199.34 between November 1, 1986 and June 30, 1987. The refund estimates for this eight month period were \$1,091,762.17. Thus, Blue Cross & Blue Shield's projected prudent buyer savings during this eight month period would be \$1,746,437.17.

Blue Cross & Blue Shield contended that the prudent buyer policy, adverse selection policy, and the marketing of HealthMate were exercises of good business judgment. Blue Cross & Blue Shield asserted that Ocean State's financial loss were due to both its being a young HMO and mismanagement. There was testimony that all young HMOs lost money in the initial years. Between June and July 1986, Ocean State attempted to reduce financial losses by switching its underwriters to United Health-Care, reducing the management fee, replacing its Chief Executive Officer, and instituting co-payments for office visits. There was conflicting testimony whether those changes were sufficient to put Ocean State in the black. Blue Cross & Blue Shield contended that between June 30, 1986 and September 30, 1986, Ocean State had profits

of \$227,123. It contended that by the end of 1986, Ocean State's profits were \$698,348. Thus, Blue Cross & Blue Shield claimed that adverse selection, HealthMate, and the prudent buyer policy did not cause Ocean State to lose money. Ocean State, however, asserted that those figures were deceptive and did not accurately reflect the impact of Blue Cross & Blue Shield's actions.

Ocean State claimed that it incurred a \$809,158 loss involving hospital discounts between January 1984 through May 1986; a \$597,016 loss of profits on enrolled members who terminated their coverage with Ocean State between November 1986 and August 1987; a \$117,591 loss of potential profits on possible state employee enrollees who did not contract with Ocean State due to the State of Rhode Island's contract with Blue Cross which offered HealthMate, between June 1986 and June 1988. Ocean State asserted that it lost \$173,013 from expected profits which failed to materialize because of Blue Cross's actions. Thus, Ocean State claimed it lost a total of \$1,696,798 due to Blue Cross's anticompetitive actions. The physicians class claimed it lost \$946,760 between January 1987 and March 1987 due to Ocean State's payments to non-participating physicians and \$1,900,000 due to the prudent buyer policy. They claimed a total loss of \$2,846,260. The jury verdicts, however, awarded \$947,000 to Ocean State and \$1,746,437 to the Plaintiff class of physicians.

The jury's verdicts in this action are at variance with the proof. On the third try, after a jury had been returned to the jury room twice for reconsideration of its verdict, the jury returned a verdict for Plaintiffs on its Section 2 Sherman Act claims, but failed to award any damages. The jury awarded damages against Blue Cross & Blue Shield on the claims of intentional interference with advantageous relationships on behalf of Ocean State in the amount of \$947,000 compensatory damages and \$250,000 punitive damages and for the class of physi-

cians in the amount of \$1,746,437 in compensatory damages.

The jury deliberated two days before returning a verdict finding Blue Cross & Blue Shield "Guilty" on both counts, the Section 2 Sherman Act violation and the common law tort of interference with advantageous relations. Initially, the jury awarded each Plaintiff, Ocean State and the class physicians, compensatory damages of \$2,693,437 (not coincidentally \$1,746,437 + 947,000) and punitive damages of \$250,000. Ocean State and the class of physicians suffered different injuries and damages. It was thus highly unlikely that each Plaintiff's award for damages would be exactly the same. Recognizing that more than mere coincidence could be a factor, the Court explained the purpose of each verdict form and that the jury must award damages separately for each Plaintiff and for each claim based on the evidence.

After further deliberation, the jury returned the second set of verdict forms. It again found Blue Cross & Blue Shield "Guilty" as to both the antitrust claims and the interference with contractual relationships claims brought by Ocean State and the class of Physicians. On the verdict form for *Ocean State v. Blue Cross & Blue Shield*, the jury listed compensatory damages of \$947,000 and punitive damages of \$250,000. On the verdict form for the class of physicians, the jury listed compensatory damages of \$1,746,437. Neither of the second set of verdict forms stated whether the awards was for damages on the antitrust claim or for interference with contractual relationships claim or both. The jury was then instructed that the verdict must clearly state the specific claims upon which it awarded damages.

After further deliberation, the jury returned its third set of verdict forms. The total amount of the damage awards equaled the same amount as the second verdict forms. The verdict form for *Ocean State v. Blue Cross & Blue Shield* stated that as to the Section 2 of Sherman

Act claim, Blue Cross & Blue Shield was guilty but awarded no damages. As to the interference with contractual relationships, the jury found Blue Cross & Blue Shield guilty and awarded Ocean State compensatory damages of \$947,000 and punitive damages of \$250,000. On the verdict form for the *Class of Physicians v. Blue Cross & Blue Shield*, the jury found Blue Cross & Blue Shield guilty of the Section 2 of the Sherman Act claim, but awarded no damages. On the interference with contractual relationships claim, the jury found Blue Cross & Blue Shield guilty and awarded the class of physicians compensatory damages of \$1,746,437.

The Defendant contends that the compensation award to Ocean State is based on the Plaintiffs' Exhibit 776 (for identification) prepared by one of Plaintiffs' damages expert and used by her as a basis for her testimony. In this the Defendant is clearly correct. Exhibit 776 is a three column simulated spreadsheet. The headings for the columns were lost profits, (Ocean State) lost hospital discounts, (Ocean State) and lost payments for the physicians' class. Under the heading lost payment to the physicians' class was a subsection entitled payments by OSPHP to non-participating physicians 1/87—3/87. This section reported \$946,260 payments Ocean State made to non-participating physicians between January 1987 and March 1987. Plaintiffs' evidence is that \$946,260 represents payments by Ocean State to "Non-Participating Physicians 1/87—3/87 \$946,260." The jury simply rounded to the next nearest thousand the \$946,260 payment to non-participating physicians to arrive at the \$947,000 and erroneously awarded it to Ocean State.

The payment Ocean State made to non-participating physicians between January and March 1987, was not a loss to Ocean State. This much the Plaintiffs must concede because they themselves claim this loss for the class of physicians. This money would have been returned to participating physicians. Ocean State budgeted the

\$946,260 to the Speciality Incentive Pools (SIP's). Ocean State was required to pay the \$946,260 to either the physicians in the SIPS pools if the Speciality Incentive Pools' costs were less than the amount budgeted or if the Speciality Incentive Pools' costs exceeded Ocean State's estimates, then the \$946,260 would have been used to reduce the Speciality Incentive Pools' excess costs. Either way, Ocean State itself could not have lost money because of payments to physicians who were not Ocean State participating physicians. The losses due to Ocean State's payments to non-participating physicians was suffered by Ocean State participating physicians. They would have received the \$946,260, if Ocean State had not had to pay that amount to non-participating physicians.

The Defendant also contends that the compensatory damages award to the certified class of physicians is based on another Plaintiffs' Exhibit, Plaintiffs' Exhibit 563. Exhibit 563 was an in house Blue Cross & Blue Shield document dated June 30, 1987 and entitled projected prudent buyer savings. Blue Cross & Blue Shield estimated that the prudent buyer policy would save a net amount of \$1,746,437.17 over an eight month period. It appears that the jury rounded the \$1,746,437.17 by omitting the 17 cents and based its awarded to the class of physicians on the amount of money Blue Cross & Blue Shield intended to save with the prudent buyer policy.

Exhibit 563 is Plaintiffs' evidence of the amount of money Blue Cross & Blue Shield expected to save due to the prudent buyer policy. It, however, does not indicate the damages the certified class of physicians incurred as a result of Blue Cross & Blue Shield's interference with their contractual relationships. The class was composed of physicians who were under contract to Ocean State and were also reimbursed by Blue Cross & Blue Shield. The withheld payments were payments Blue Cross & Blue Shield did not make to Blue Cross & Blue Shield physicians. Ocean State contracted physicians therefore had

no right to receive the withheld payments, except if they also participated in Blue Cross & Blue Shield and their payments had been reduced by Blue Cross & Blue Shield. Since Blue Cross & Blue Shield had many more participating physicians than Ocean State, there is no basis to conclude, as the jury did, that the withheld payments belonged to Ocean State physicians who were reimbursed by Blue Cross & Blue Shield. It is inappropriate to conclude that the certified class of physicians must have incurred losses equal to Blue Cross & Blue Shield's prudent buyer savings.

DISCUSSION

Standard of Review

In actions which blend claims for both legal relief in terms of monetary damages and equitable relief by way of injunction, a jury shall first determine the issue of damages. *Beacon Theatres, Inc. v. Westover*, 359 U.S. 500, 79 S.Ct. 948, 3 L.Ed.2d 988 (1959); *Dairy Queen, Inc. v. Wood*, 369 U.S. 469, 479, 82 S.Ct. 894, 900, 8 L.Ed.2d 44 (1962); *Wallace Motor Sales v. American Motor Sales Corp.*, 780 F.2d 1049, 1066 (1st Cir. 1985). The effect of a jury's determination as in this instance is significant. Here the jury returned a verdict that the Defendant Blue Cross & Blue Shield was guilty of violating Section 2 of the Sherman Act (15 U.S.C. § 2). The jury declined, after three attempts, to assess monetary damages. Generally speaking, it has been held that since the legal issues are to be heard first in an action under Section 2 of the Sherman Act (15 U.S.C. § 2), findings by the jury in the damages action, also involved in the application for equitable relief, are binding upon the trial court in its later consideration of the facts involved in equitable relief applications. *Florists' Nationwide Tel. Del. Net. v. Florists' Tel. Del. Assn*, 371 F.2d 263, 271 (7th Cir.) cert. denied, 387 U.S. 909, 87 S.Ct. 1686, 18 L.Ed.2d 627 (1967); *Calnetics Corp. v. Volkswagen of*

America, Inc., 532 F.2d 674, 690 (9th Cir.), cert. denied, 429 U.S. 940, 97 S.Ct. 355, 50 L.Ed.2d 309 (1976).

Indeed, the parties in this action, although in disagreement on almost every issue, seem to be in agreement on this aspect, to the effect that this Court is bound by the jury's determination of the factual issues. Thus, Plaintiffs are able to assert that the jury has concluded that Defendant's business practices of the prudent buyer policy, selective marketing of Healthmate, and its adverse selection policy were anti-competitive and illicit activity contrary to the purpose of the Sherman Act to provide competition, and, that these determinations bind this Court. Of course, Blue Cross & Blue Shield argues that since no damages were awarded, Plaintiffs have failed to prove injury, and therefore, the Sherman Act counts fail. However, before the Court determines to what extent it is bound by the findings of the jury, it will first determine if the jury verdict is supported by the evidence at all.

The standard of review in setting aside a jury verdict is narrow. In determining the motion for judgment notwithstanding the verdict, the Court must evaluate the evidence in the light most favorable to Plaintiffs. *Rios v. Empresas Lineas Maritimas Argentinas*, 575 F.2d 986, 989 (1st Cir. 1978). But the plaintiffs are not entitled to unreasonable inferences based on speculation and conjecture. See *Carlson v. American Safety Equip. Corp.*, 528 F.2d 384 (1st Cir. 1976); *Schneider v. Chrysler Motors Corp.*, 401 F.2d 549, 555 (8th Cir. 1968). A motion for judgment notwithstanding the verdict should be granted "... when as a matter of law, no conclusion but one can be drawn." *CVD, Inc. v. Raytheon Co.*, 769 F.2d 842, 849 (1st Cir. 1985) (citing *United States v. Articles of Drug Consisting of the Following*, 745 F.2d 105, 113 (1st Cir. 1984), cert. denied sub nom., 470 U.S. 1004, 105 S.Ct. 1358, 84 L.Ed.2d 379 (1985)), cert. denied, 475 U.S. 1016, 106 S.Ct. 1198, 89 L.Ed.2d 312 (1986).

Therefore a motion for judgment notwithstanding the verdict should be denied if after reviewing the evidence in the light most favorable to the plaintiffs and drawing all reasonable inferences in their favor, there is sufficient evidence to support the verdict. *Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 9 (1st Cir. 1979), cert. denied, 446 U.S. 983, 100 S.Ct. 2964, 64 L.Ed.2d 839 (1980); *CVD, Inc.*, 769 F.2d at 849. A jury verdict supported by the evidence may not be set aside simply because the judge would have reached a different result. See *Coffran v. Hitchcock Clinic, Inc.*, 683 F.2d 5, 6 (1st Cir.), cert. denied, 459 U.S. 1087, 103 S.Ct. 571, 74 L.Ed.2d 933 (1982).

The standard of review for granting a new trial is not as stringent as for granting a judgment notwithstanding the verdict. But the trial judge may not set aside a verdict simply because he or she would have reached a different verdict. *Borras v. Sea-Land Serv., Inc.*, 586 F.2d 881, 887 (1st Cir. 1978). In granting a motion for a new trial the judge must find that "the verdict is against the clear weight of the evidence, or is based upon evidence which is false, or will result in a clear miscarriage of justice." *Milone v. Moceri Family, Inc.*, 847 F.2d 35, 37 (1st Cir. 1988); see *CVD, Inc.*, 769 F.2d at 848 (citing *Coffran* 683 F.2d at 6).

The Court will first determine whether there is sufficient evidence to support the jury verdict on the antitrust claims and the claims for the interference with contractual relationships. Then the Court will address the applications for injunctive and declaratory relief.

ANTITRUST CLAIMS

With respect to the Defendant's motion for judgment n.o.v. on the antitrust claims, it asserts two legal theories. First, the Defendant contended that the jury's findings of "no damages" for the antitrust claims indicated that no injury resulted to Plaintiffs' business or property as a

result of antitrust violations. Thus, it contends no liability arose for a private damage action under the Clayton Act, Section 4. 15 U.S.C. § 15 (Supp. 1988). Noting that the Plaintiffs suffered no injuries as a result of the Defendant's conduct, Defendant concludes that Plaintiffs failed to prove all elements of an antitrust violation and requested the Court to enter judgment in its favor on the Sherman Act Section 2 claims.

Defendant's argument warrants some attention as a ground for granting Defendant's motion for judgment notwithstanding the verdict on the antitrust claims. Plaintiffs filed this action seeking treble damages under Section Fifteen of the Sherman Act, 15 U.S.C. § 15. (Supp. 1988). It is a remedial provision of the Sherman Act. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 485, 97 S.Ct. 690, 695, 50 L.Ed.2d 701 (1977). It frequently has been called the private attorney general provision of the antitrust laws because a private Plaintiff rather than the government may maintain an action for an alleged antitrust violation. *See, e.g., Hawaii v. Standard Oil Co.*, 405 U.S. 251, 262, 92 S.Ct. 885, 891, 31 L.Ed.2d 184 (1972); *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 131, 89 S.Ct. 1562, 1580, 23 L.Ed.2d 129 (1969); *United States v. Borden Co.*, 347 U.S. 514, 518, 74 S.Ct. 703, 706, 98 L.Ed. 903 (1954). Section Fifteen of the Sherman Act, more commonly known as Section Four of the Clayton Act, provides that a Plaintiff can recover threefold the damages he sustains and the cost of the suit, including attorney's fees if the Plaintiff shows an injury in his business or property by reason of anything forbidden in the antitrust laws. *See 15 U.S.C. § 15 (Supp. 1988)*. So for Plaintiffs to prevail on their antitrust claims, they must prove ". . . a violation [of the antitrust laws] and additionally show to a reasonable degree of certainty that there has been injury to them by reason of the violation." *See International Travel Arrangers, Inc. v. Western Airlines, Inc.*, 623 F.2d 1255, 1270 (8th Cir.), cert. denied,

449 U.S. 1063, 101 S.Ct. 787, 66 L.Ed.2d 605 (1980). To establish an antitrust violation, Plaintiffs must show that Blue Cross & Blue Shield engaged in monopolization acts in violation of Section Two of the Sherman Act. Section Two of the Sherman Act defines the criminal violation of monopolization and its penalties. 15 U.S.C. § 2 (Supp. 1988). But the mere existence of a violation cannot support a private action under Section Four of the Clayton Act. *See Gray v. Shell Oil Co.*, 469 F.2d 742, 749 (9th Cir. 1972), *cert. denied*, 412 U.S. 943, 93 S.Ct. 2773, 37 L.Ed.2d 403 (1973). Plaintiffs must show that they suffered an injury to business or property as a result of the antitrust violation. *See Hawaii*, 405 U.S. at 262, 92 S.Ct. at 891. What constitutes an injury to business or property is less than clear. The words "business or property" refer to commercial interest. *See id.* at 264, 92 S.Ct. at 892. However, injury to business or property is defined in terms of a tautology. Since Section 4 of the Clayton Act provides a money damages remedy, it must be an injury which the jury is able to quantify in dollars. It is the kind of injury that the antitrust laws were designed to prevent, namely damage as a result of anti-competitive conduct. *See Brunswick Corp.*, 429 U.S. at 489, 97 S.Ct. at 697. Plaintiffs do not have to prove that the antitrust violation was the sole cause of the injury. *See Zenith Radio Corp.*, 395 U.S. at 114, 89 S.Ct. at 1571. But the Plaintiffs must show a causal relationship between the injury and the violation. *See id.* at 114 n.9, 89 S.Ct. at 1571-72 n.9. Furthermore, the Plaintiffs must prove some indication of the amount of damages. *See, e.g., Construction Aggregate Transport, Inc. v. Fla. Rock Indus.*, 710 F.2d 752, 782 (11th Cir. 1983); *Larry R. George Sales Co. v. Cool Attic Corp.*, 587 F.2d 266, 270 (5th Cir. 1979); *Terrell v. Household Goods Carriers' Bureau*, 494 F.2d 16, 20 (5th Cir.), *cert. denied*, 419 U.S. 987, 95 S.Ct. 246, 42 L.Ed.2d 260 (1974). Thus, "[t]o be 'liable' under the antitrust laws . . . means that one has to violate the antitrust laws and that violation

has resulted in an injury to the business or property of the plaintiff, *i.e.*, there was fact of damage." *Response of Carolina, Inc. v. Leasco Response, Inc.*, 537 F.2d 1307, 1320 (5th Cir. 1976).

The jury's award of no damages on the antitrust claims indicates that they found that the Plaintiffs were not damaged by an antitrust violation. The Court of Appeals for the District of Columbia confronted a similar situation. *See Association of Western Rys. v. Riss & Co.*, 299 F.2d 133, 134-35 (D.C.Cir) cert. denied, 370 U.S. 916, 82 S.Ct. 1555, 8 L.Ed.2d 498 (1962). There the jury returned a verdict against the Defendant but did not award any damages. *See id.* The Court of Appeals concluded that the verdict plainly meant that the Defendants conspired but that the conspiracy did not damage the Plaintiff. *See id.* at 135. As a result, the court held that Plaintiff had not proved its claim because it failed to show damages. *See id.*

In this matter, the jury's determination of no damages means exactly that. The Court must conclude that Plaintiffs failed to sustain their burden of showing damages to their business or property as a result of an antitrust violation. With this conclusion in mind, the result is preordained. Thus, Plaintiffs have not proved their treble damage antitrust claims and the Defendant is entitled to a judgment notwithstanding the verdict on those claims.

Defendant's second theory is that it is entitled to entry of judgment in its favor as a matter of law on the remaining antitrust claims. Blue Cross argues that there was insufficient evidence to establish antitrust violations because of the prudent buyer policy, selective marketing of HealthMate, and adverse selection policies. Therefore, the Defendant reasons that the Court is required to enter judgment in its favor as a matter of law. A more in depth analysis of prudent buyer, adverse selection, and the selective marketing of HealthMate is needed before

conclusions may be drawn on whether they separately or collectively violate antitrust laws.

First, Blue Cross contends that the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, exempted adverse selection and the selective marketing of HealthMate from the antitrust laws. The Defendant claims that adverse selection and HealthMate constituted the business of insurance regulated by state law; therefore, those programs were exempt under the Sherman Act. On the other hand, Plaintiffs claim health service corporations are not in the business of insurance so they are not eligible for the McCarran-Ferguson exemption to the antitrust laws. There is substantial support for the Plaintiffs' contention. *See Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed.2d 261 (1979). There is respectable authority to the contrary. *See Health Care Equalization Comm. v. Iowa Medical Soc'y*, 851 F.2d 1020 (8th Cir.1988). However, as it is made clear hereafter there is no need to presently resolve this conflict.

The question is whether or not the prudent buyer policy, adverse selection and the selective marketing of HealthMate violate antitrust laws. Plaintiffs must prove the following elements by a preponderance of the evidence:

First, that the Defendant had monopoly power in a relevant market;

Second, that the Defendant willfully acquired or maintained that power through restrictive or exclusionary conduct;

Third, that Defendant's activities occurred in or affected interstate commerce; and

Fourth, that Plaintiff was injured in its business or property because of Defendant's restrictive or exclusionary conduct.

See, e.g., *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1704, 16 L.Ed.2d 778 (1966); *Forro Precision, Inc. v. Intern. Business Mach. Corp.*, 673 F.2d 1045, 1058 (9th Cir.1982); *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 272-76 (2d Cir. 1979), cert. denied, 444 U.S. 1093, 100 S.Ct. 1061, 62 L.Ed.2d 783 (1980).

The terms "monopoly power" and "market power" are generally used interchangeably. P. Areeda & D. Turner, *Antitrust Law*, § 529 at 388 (1978). "Monopoly power" is the power to control prices or exclude competition in a relevant market. *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391, 76 S.Ct. 994, 1005, 100 L.Ed. 1264 (1956). The relevant market is the "area of effective competition" where the defendant operates. *Standard Oil Co. v. United States*, 337 U.S. 293, 299 n. 5, 69 S.Ct. 1051, 1055 n. 5, 93 L.Ed. 1371 (1949). Relevant market is identified by the product and its interchangeability plus the geographic area. See *Brown Shoe Co. v. United States*, 370 U.S. 294, 336-37, 82 S.Ct. 1502, 1530, 8 L.Ed.2d 510 (1962); *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 399, 76 S.Ct. 994, 1009, 100 L.Ed. 1264 (1956). Usually the trier of fact defines the relevant market. See *International Boxing Club, Inc. v. United States*, 358 U.S. 242, 245, 79 S.Ct. 245, 247, 3 L.Ed.2d 270 (1959).

Blue Cross contended that as between the class of physicians and Blue Cross they are not in the same relevant market. Physicians were not sellers of health insurance and therefore in reality are not head to head competitors of Blue Cross. Without a relevant market existing between Blue Cross and the class of physicians, Blue Cross claimed it could not engage in anticompetitive acts which could harm the class. The only effect if at all on the class due to Blue Cross's actions, it contends is indirect. In addition, Blue Cross hypothesized that even if it possessed 100% share of the health care financing

market, the physician class would not have any antitrust claim because it derives only a small portion of its income from Blue Cross insureds. Noting that physicians are paid from many sources including Medicare, Medicaid, commercial insurance carriers, self-insured employers, and patients directly, Blue Cross claims that there was no evidence that Blue Cross represented any more than 30% of the dollar purchases of physician services. Thus, it contends, it could not possess monopoly power and could not have engaged in anticompetitive conduct.

Defendants are confusing relevant market with standing to sue. It is not a requirement to an antitrust suit that plaintiff and defendant be in the same relevant market. *See Blue Shield of Va. v. McCready*, 457 U.S. 465, 478-81, 102 S.Ct. 2540, 2547-49, 73 L.Ed.2d 149 (1982). Plaintiff, however, must meet the standing requirement that it allege that it suffered an injury to its business or property as a result of the Defendant's conduct. *See* 15 U.S.C. § 15 (1982). The First Circuit requires that the persons injured by the alleged antitrust violation be within a target area, which draws a line and excludes persons whose injuries are too remote. *See Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 17-19 (1st Cir.1979).

The class of physicians have asserted an injury to their business or property as a result of the alleged antitrust violation, i.e. the loss of reimbursement from the SIP's pool because of payments to nonparticipating physicians. Their alleged injury is within the target area. Thus, the class of physicians have standing to sue even though they may not be participants in the same relevant market as Blue Cross & Blue Shield.

Blue Cross & Blue Shield acquired its market share before Ocean State's creation. The undisputed evidence is that Blue Cross & Blue Shield was for years essentially the sole private health care cost insurer in the State of

Rhode Island. Not only did Blue Cross & Blue Shield have a better "mousetrap," it had the only "mousetrap" in town. As time went on, the industry changed with the development of health maintenance organizations. Rhode Island Group Health Association (RIGHA) appeared in 1971. Its physicians were employed by RIGHA and a subscriber was required to select a RIGHA physician. This plan had some disadvantage from the point of view of the subscriber, who heretofore had been accustomed to free selection of his or her own physician. Ocean State was a natural progression of the Health Maintenance format. It entered into contracts with almost half the physicians in the State of Rhode Island, providing patients with a wider choice of their respective physicians. It is obvious that a natural tension would develop between Blue Cross & Blue Shield and Ocean State and that physicians would seek the continuance of both plans in order that they could contract with both plans. It is not without significance that it was not Blue Cross & Blue Shield customers who have complained. The Plaintiffs are Ocean State and some physicians. The market involved is a market which provides means to finance health care. There is no proof that competition for physician services has been affected, or that any payment to which a physician is entitled has been lost. The claim is that purchasers of health insurance have been corralled by Blue Cross & Blue Shield to the competitive disadvantage of its competitors. The genesis of this complaint is the response of Blue Cross & Blue Shield to market conditions and the circumstances extant in the spring, summer and fall of 1986.

Both Blue Cross & Blue Shield and Ocean State were facing difficult financial conditions in the spring of 1986. They were both losing money. The largest single contract involving the employees of the State of Rhode Island was due for competitive bids at the end of June 1986. At that time Ocean State had not been able to return the 20% it had retained from its contracted phy-

sicians for the calendar year 1985. Thus, Ocean State physicians, who had also contracted with Blue Cross charged 20% less to Ocean State than the same physicians had charged Blue Cross for precisely the same services. In this mix, Blue Cross & Blue Shield created its HealthMate plan, originally called "Z Plan", "MAPS Plus", and "PLAN 10 PLUS". Blue Cross & Blue Shield's market share permitted it to develop both the prudent buyer policy, adverse selection, and HealthMate.

"The connection between market share and market power is far from clear." See P. Areeda, *supra* at 328. Size alone does not violate the Sherman Act. *United States v. United States Steel Corp.*, 251 U.S. 417, 40 S.Ct. 293, 64 L.Ed. 343 (1920). Courts, however, must consider the market share of the alleged monopolist as an important factor in determining the existence of monopoly power. See, e.g., *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 86 S.Ct. 1698, 1704, 16 L.Ed.2d 778 (1966); *American Tobacco Co. v. United States*, 328 U.S. 781, 797, 66 S.Ct. 1125, 1133, 90 L.Ed. 1575 (1946); *United States v. Aluminum Co. of America*, 148 F.2d 416, 424 (2d Cir.1945). In unregulated industries, courts measure market power by defining the relevant product and geographic market and compute the defendant's market share. See *Southern Pacific Communications v. American Tel. & Tel.*, 740 F.2d 980, 1000 (D.C.Cir.1984), (citing *United States v. E.I. du Pont de Nemours & Co.*, 351 U.S. 377, 391, 76 S.Ct. 994, 1005, 100 L.Ed. 1264 (1956)), cert. denied 470 U.S. 1005, 105 S.Ct. 1359, 84 L.Ed.2d 380 (1985). In a regulated industry, such as health care insurance, a heavy reliance on market share statistics probably would be an inaccurate or misleading indication of monopoly power. See *Southern Pacific Communications*, 740 F.2d at 1000; *MCI Communications Corp. v. American Tel. and Tel. Co.*, 708 F.2d 1081, 1107 (7th Cir.), cert. denied, 464 U.S. 891, 104 S.Ct. 234, 78 L.Ed.2d 226 (1983). Thus, the size of a regulated com-

pany's market share should be a point of departure in determining the existence of monopoly power. *Id.* at 1107. Other factors such as size of competitors, degree of barriers to entry, pricing trends and practices and technological superiority may be considered in determining market power. *See, e.g., United States v. E.I. du Pont de Nemours & Co.*, 96 F.T.C. 650, 762 (1980); *International Distrib. Centers, Inc. v. Walsh Trucking Co., Inc.*, 812 F.2d 786 (2d Cir.1987); *Fishman v. Estate of Wirtz*, 807 F.2d 520, 532-39 (7th Cir.1986). A monopoly power analysis must focus directly on the defendant's ability to control prices or exclude competition. *MCI Communications Corp.*, 708 F.2d at 1107. It is essential to also keep in mind the fact that the antitrust laws were enacted for the protection of competition, not competitors. *See Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488, 97 S.Ct. 690, 697, 50 L.Ed.2d 701 (1977) (citing *Brown Shoe Co. v. United States*, 370 U.S. 294, 320, 82 S.Ct. 1502, 1521, 8 L.Ed.2d 510 (1962)).

The evidence established that Blue Cross provides in Rhode Island private nongovernment health care financing for a major market share. It is not contended that because of Blue Cross & Blue Shield's dominant market position, it has charged its customers, the persons insured by Blue Cross & Blue Shield more than they should have been charged. There is no suggestion that Blue Cross & Blue Shield has not obtained the best economic benefit for its subscribers. Indeed, the complaint is at bottom that because of Blue Cross & Blue Shield's market power, it has been able to get a better deal for medical services than Ocean State and that because of its market power, physicians have the awful choice of yielding to its fee schedule or losing their patients who are Blue Cross & Blue Shield subscribers. At the same time the evidence is clear that Blue Cross & Blue Shield face intense competition from Ocean State and RIGHA. Also, insurance

companies with national bases are becoming more involved in the Rhode Island market. Large employers have become self insurers. Thus, although Blue Cross & Blue Shield has market power, it is not without limit. There is a competitive market. The argument goes that since so many persons are enrolled in Blue Cross & Blue Shield in the State of Rhode Island what it does must be considered in the context of its market power. So much is true. The question is did it use its obvious market power in an anti-competitive manner? *See, e.g., Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 105 S.Ct. 2847, 86 L.Ed.2d 467 (1985); *United States v. Grinnell Corp.*, 384 U.S. 563, 86 S.Ct. 1698, 15 L.Ed.2d 778 (1966); *Lorain Journal Co. v. United States*, 342 U.S. 143, 72 S.Ct. 181, 96 L.Ed. 162 (1951), *see also United States v. United Shoe Mach. Corp.*, 110 F.Supp. 295 (D. Mass. 1953), *aff'd*, 347 U.S. 521, 74 S.Ct. 699, 98 L.Ed. 910 (1954).

What is anti-competitive activity is not a matter that has been clearly defined. There are some significant signposts along the way, but the route is not so clearly marked that departures are unavoidable. It is blandly stated that “[t]he use of monopoly power, however, lawfully acquired, to foreclose competition, to gain a competitive advantage, or to destroy a competitor, is lawful under the Sherman Act.” 54 Am.Jur.2d § 42, at 692 (citing *Home Placement Service, Inc. v. Providence Journal Co.*, 682 F.2d 274 (1st Cir. 1982), *cert. denied*, 460 U.S. 1028, 103 S.Ct. 1279, 75 L.Ed.2d 500 (1983)). But what is the anticompetitive behavior which must be condemned? Theorists have not done much to illuminate the essential elements. Thus, Areeda talks in terms of exclusionary conduct not competitive on the merits and not more restraint than reasonably necessary to maintain competition. *P. Areeda, supra* ¶ 655(b) n. at 72-73. Courts have adopted Areeda's definition of exclusionary conduct which includes “behavior that not only (1) tends

to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." See, e.g., *Aspen Skiing Co.*, 472 U.S. at 605, 105 S.Ct. at 2859 (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78 (1978)); *Barry Wright Corp. v. ITT Grinnel Corp.*, 724 F.2d 227, 230 (1st Cir.1983) (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626 at 83 (1978)); *Instructional Sys. Dev. Corp. v. Aetna Cas. and Sur. Co.*, 817 F.2d 639, 649 (10th Cir.1987) (citing 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 625b (1978)).

It is crucial to differentiate "between practices which tend to exclude or restrict competition . . . [from practices that result from] the success of a superior product, a well-run business, or luck, on the other [hand]", the very essence of competition. *Aspen Skiing Co.*, 472 U.S. at 604, 105 S.Ct. at 2858. Examples of the effect of competition on the merits are non-exploitative pricing, higher output, improved product quality, energetic market penetration, successful research and development, and cost-reducing innovations. See *Aspen Skiing Co.*, 472 U.S. 585, 105 S.Ct. 2847; *United States v. Aluminum Co. of America*, 148 F.2d 416 (2d Cir.1945). Blue Cross & Blue Shield has historically been very successful. On the other hand, Ocean State's penetration of the market has been phenomenal. With these general principles in mind, the specific aspects of Blue Cross & Blue Shield's adverse selection, HealthMate, and prudent buyer policies must be examined.

Adverse selection is criticized because it is claimed that the number of subscribers who it was estimated would leave Blue Cross was too high. The obvious import of this circumstance would be to increase the cost of Blue Cross & Blue Shield. It is a curious argument indeed by a competitor that Blue Cross & Blue Shield was charging too much for its product. Competitors could hardly be injured by an increase in price. *Matsushita*

Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 583, 106 S.Ct. 1348, 1354, 89 L.Ed.2d 538 (1986). What is more significant is that no one disputes that adverse selection was a fact. Healthier persons would tend to enroll in an HMO. If they did so, then without doubt Blue Cross & Blue Shield would be left with more expensive subscribers. The dispute posited by Plaintiffs is that fewer subscribers would leave Blue Cross & Blue Shield than Blue Cross & Blue Shield estimated. This is hardly the basis of an antitrust claim. Certainly, business people have some area of reasonable and responsible legitimate judgment. This is such an instance.

HealthMate is the result of research and development which concluded that HMO's will have a major role in health care financing in the future. Although HealthMate is not an HMO, it was Blue Cross's attempt to provide a health care financing plan comparable to an HMO until Blue Cross could establish an HMO program. Antitrust laws support the introduction of new products, such as HealthMate, because it encourages competition. *See Berkey Photo, Inc.*, 603 F.2d at 263. If Blue Cross & Blue Shield were foreclosed by the Sherman Act from competing in an HMO format, the Plaintiff Ocean State would then have major HMO market share in Rhode Island. This use of the Sherman Act would produce obvious anticompetitive effects.

The selective marketing of HealthMate does not negate the policy reason for encouraging HealthMate. Offering HealthMate as an option to subscribers who are eligible for Ocean State, is head to head competition between Ocean State and Blue Cross and that competition benefits consumers by providing them with alternative health care financing options. It is only because of Ocean State's decision not to compete that the product is not offered elsewhere. Ocean State seeks, therefore, to benefit from its lack of competitive effort in areas where for reasons to its advantage it decides not to compete.

With respect to the prudent buyer program, Plaintiffs asserted that there was sufficient evidence to show that the prudent buyer program was exclusionary. They contended that the prudent buyer had the purpose and effect of maintaining the Defendant's monopoly power and was not a legitimate money saving policy. Noting the testimony of Ronald Battista, Senior Vice President of Professional Relations at Blue Cross & Blue Shield, that prudent buyer was not designed to produce savings for Blue Cross, Ocean State concluded that prudent buyer had an anticompetitive purpose. Relying on Blair Suellentrop's, Chief Executive Officer of Ocean State, testimony regarding the decline in Ocean State's enrollment and resignation of participating physicians, Ocean State concluded that the prudent buyer policy was instituted to harm Ocean State. Indeed, it was Ocean State who claimed that the testimony of Ronald Battista, Blair Suellentrop, and Douglas McIntosh, Chief Executive Officer of Blue Cross & Blue Shield, established sufficient evidence to show that the prudent buyer program was anticompetitive.

On the contrary, Mr. Battista's and Mr. McIntosh's testimony indicated that prudent buyer was instituted to assure that Blue Cross's payments to physicians were not more than Ocean State's payments to physicians. There was no evidence that securing comparable fees for physician services resulted in any anticompetitive effect or impaired Ocean State's competitive opportunities. That the policy had the effect of harming Ocean State was inevitable, but was from the point of view of the consumer clearly understandable. The harm that came Ocean State's way was the resignation of some of its physicians, and claimed increased costs. This harm has to do with the market for physicians' services and the election by physicians of a course which they considered most beneficial to their financial point of view. As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same services is

anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

Relying on *Kartell v. Blue Shield of Mass.*, Defendant claimed that prudent buyer was a legitimate defense under a "most favored nations clause" which was designed to protect Blue Cross from paying more for the same services than competitors. 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985). Blue Cross analogized the prudent buyer policy of this case with the no balance billing policy in *Kartell*. *See id.* In *Kartell*, the First Circuit held that Blue Cross was a purchaser of health services and as such had the right to require participating physicians not to balance bill patients who are Blue Cross subscribers. *Id.* Blue Cross argued that as a purchaser of health services it has a lawful right to bargain with its suppliers, the physicians, for the best possible price terms. Blue Cross is a purchaser of health services. The more Blue Cross's activities resemble a purchaser the less likely that they are unlawful. *See id.* at 925 As a legitimate buyer, Blue Cross is entitled to use its market power to get the best price for the services it purchases. *See id.* at 929. Therefore, the prudent buyer policy is clearly not anticompetitive and does not violate the anti-trust laws.

Indeed, if Plaintiffs are correct in their contention that the prudent buyer policy is anticompetitive, it is impossible not to come to the same conclusion regarding Ocean State's SIPS plan. There is no principle of anti-trust law which would deny a business practice to any entity with market power and permit that practice on the part of competitor who does not have market power. To hold prudent buyer anticompetitive would have given and would give Ocean State an unfair competitive advantage in the market, a result which is antithetical to the purpose of the Sherman Act and economically detrimental to health care consumers.

The Defendant's motion for a judgment notwithstanding the verdict is granted on the antitrust claims. The adverse selection programs, prudent buyer program, and the selective marketing of HealthMate are not anticompetitive and do not violate the antitrust laws. There can be no conclusion other than that these programs benefit consumers and represent legitimate responses to competitive conditions.

ADDITIONAL

The physicians' class seeks a \$1.9 million dollar additur on the antitrust claim. Relying on the testimony of Thomas Aman and Ronald Battista, Defendant's witnesses, who both testified that Blue Cross retained at least \$1,900,000 from Ocean State participating physicians and the physicians' class who claimed that Blue Cross retained \$1,900,000 from Ocean State participating physicians, Plaintiffs concluded that there was no valid dispute concerning the Blue Cross withhold. Therefore, the \$1,900,000 that Blue Cross withheld may be considered as the damage for the antitrust violation. In light of the jury's verdict and the Court's determination of the Defendant's motion for judgment notwithstanding the verdict on the antitrust claim, Plaintiffs' motion for additur must be denied.

INTERFERENCE WITH CONTRACTUAL RELATIONSHIPS

Next, it is necessary to determine whether the prudent buyer, adverse selection, or the selective marketing of HealthMate interfere with the contractual relationships between Ocean State and its participating physicians. Plaintiffs claimed that Ocean State and the class of physicians incurred damages under their contracts due to the Defendant's actions. Ocean State argued that its advertising budget had to be increased beyond what it expected to spend and above the average advertising expenditures for HMO of its size. Ocean State claimed it

incurred additional advertising expenses of \$335,000 due to Blue Cross & Blue Shield's actions and the subsequent negative publicity. In addition, Ocean State claimed that it lost profits of \$173,013 because prospective members did not enroll due to the Defendant's actions. Ocean State, also, contended that it incurred unbudgeted expenses of up to \$1,053,740 to retain physicians in certain specialties. The jury did not award any of these claimed damages to Ocean State.

The class of physicians claimed that the money Blue Cross & Blue Shield withheld caused the class to suffer damages. In addition, plaintiffs contended that the class of physicians lost \$946,760, which represented the additional moneys Ocean State paid to non-participating specialists. These damages were erroneously awarded to Ocean State.

Defendant claimed that it did not interfere with Ocean State's contractual relationships with the class of physicians. It asserted that there was no evidence that any act by Blue Cross & Blue Shield made more difficult the performance of the Ocean State contracts or lessened their value. Blue Cross & Blue Shield, also, contended that the class' contracts were not terminated, breached, or altered in any sense.

The Defendant argued that the jury awards on the interference with contractual relationships were not based on evidence. Furthermore, Defendant claimed that the \$947,000 the jury awarded Ocean State represented lost payments to the physicians' class and that Ocean State never claimed that amount as its damages. Therefore, the Defendant contended that the evidence does not support an award of \$947,000 to Ocean State.

Blue Cross & Blue Shield argued that the \$1,746,437 awarded to the class of physicians represented Blue Cross & Blue Shield's estimated savings through the prudent buyer plan for an eight month period. It did not repre-

sent the damages to the class of physicians. The Defendant's contentions have substantial basis. Although the class claims that the \$1,746,437 equals its damages the class ignores the fact that many physicians who are not in the class were among those from whom full payment was withheld. The Defendant further contends that there was no evidence from which a reasonable jury could award any damages.

The Rhode Island Supreme Court defined the basic elements of a claim for tortious interference with contractual relationships in *Smith Dev. Corp. v. Bilow Enter. Inc.*, 112 R.I. 203, 211, 308 A.2d 477, 482 (1973). Later cases have adopted these elements for a claim of tortious interference with prospective contractual relationships. See, e.g., *Roy v. Woonsocket Inst. for Sav.*, 525 A.2d 915, 979 (R.I.1987); *Mesolella v. City of Prov.*, 508 A.2d 661, 670 (R.I.1986); *Federal Auto Body Works, Inc. v. Aetna Cas. & Sur. Co.*, 447 A.2d 377, 380-81 (R.I.1982). Plaintiff must prove by the preponderance of the evidence that a contract existed, that the alleged wrongdoer's interference was intentional, and that damages resulted from it. *Smith Dev. Corp.*, 112 R.I. at 211, 308 A.2d at 482. The Plaintiff must show that the Defendant intended to do harm without justification. *Mesolella*, 508 A.2d at 670. The Defendant has the burden of proving sufficient justification for an interference. *Smith Dev. Corp.*, 112 R.I. at 211, 308 A.2d at 482.

The Plaintiffs have met their burden of proving that contracts existed between Ocean State and Ocean State participating physicians and that Blue Cross knew of these contracts. The Plaintiffs, however, have failed to present any evidence that Blue Cross intentionally interfered with the contracts by implementation of the prudent buyer program, adverse selection, and the selective marketing of HealthMate. The only evidence was that some physicians perceived it to be to their economic ad-

vantage to terminate their relationship with Ocean State in accord with the terms of their agreement with Ocean State because of the prudent buyer policy. Translating this circumstance into an intentional interference by Blue Cross & Blue Shield with a contractual relationship is quite clearly absurd. Blue Cross & Blue Shield announced what it was willing to pay. Some physicians, not willing to give Blue Cross & Blue Shield a discount, resigned from Ocean State as permitted by their contract with Ocean State. There is no evidence of intentional interference with the contract between the class of physicians and Ocean State. Further, prudent buyer, adverse selection, and the selective marketing of HealthMate were justified courses of action that Blue Cross undertook as appropriate competition so that its subscribers would not be further burdened. Absent these programs, Blue Cross would pay more to the same physicians for their services than Ocean State. Blue Cross & Blue Shield would be subject to additional expense because of healthier subscribers transferring to an HMO because Blue Cross subscribers would lack a program comparable to Ocean State's coverage. It is obvious that Blue Cross acted with justification and therefore, the prudent buyer policy, adverse selection, the selective marketing of HealthMate were without doubt, justified responses to competitive conditions. Defendant's motion for judgment notwithstanding the verdict on the interference of contractual relationships must be and is granted.

Further, the jury verdict that Defendant was liable on the claim of tortious interference with contractual relationships was against the clear weight of the evidence that Blue Cross justifiably instituted the prudent buyer policy, adverse selection, and the selective marketing of HealthMate. Also, the damages awarded by the jury were inappropriate. A new trial is required to prevent injustice. Giving full respect to the jury's determination, the Court is left with the firm conviction that a mistake

has been committed in that damage amounts have been awarded to parties who are not entitled to them. Therefore, Defendant's motion for a new trial on the intentional interference with contractual relationships is also granted.

INJUNCTIVE RELIEF

Plaintiffs and Defendant seek injunctive relief. Plaintiffs move to enjoin Blue Cross from continuing the prudent buyer program or implementing a similar program and to restrain the marketing of HealthMate. The Defendant moves to enjoin the Plaintiff-Intervenors from engaging in the illegal practices alleged and to restrain the Physician and Surgeons Association of Rhode Island, Inc. from negotiating or attempting to negotiate collectively physician fees with Blue Cross.

Although Plaintiffs and Defendant seek equitable relief for different purposes, the burdens of proof are the same for each moving party. Congress enacted Section 16 of the Clayton Act to permit private actions for equitable relief. 15 U.S.C. § 26 (Supp.1988). Section 16 of the Clayton Act, reads in part: "[a]ny person . . . [or] corporation . . . shall be entitled to sue for injunctive relief . . . against threatened loss or damage by a violation of the antitrust laws . . . under the same conditions and principles as injunctive relief against threatened conduct that will cause loss or damage . . ." 15 U.S. § 26 (Supp. 1988). Injunctive relief is available to private parties when the traditional equity principles are met and there is a demonstration of a threatened injury. *See, e.g., Hawaii v. Standard Oil Co.*, 405 U.S. 251, 260, 92 S.Ct. 885, 890, 31 L.Ed.2d 184 (1972); *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 130, 89 S.Ct. 1562, 1580, 23 L.Ed.2d 129 (1969); *Cia. Petrolera Caribe, Inc. v. Arco Caribbean, Inc.*, 754 F.2d 404, 407-08 (1st Cir. 1985). The traditional elements that a moving party must show for injunctive relief are: 1) irreparable harm to the Plaintiff if the injunction is not granted, 2)

inadequacy of a legal remedy, 3) that the public interest will not be adversely affected by granting the injunction; 4) that the harm to Plaintiff outweighs any harm to the Defendant by granting the injunction. But in order to prevail, Plaintiff must "demonstrate a significant threat of injury from an impending violation of the antitrust laws." *See id.* 395 U.S. at 130, 89 S.Ct. at 1580. Plaintiff need only show a threat of injury not an actual injury. *See Zenith Radio Corp.*, 395 U.S. at 130, 89 S.Ct. at 1580; *Cia. Petrolera Caribe, Inc.*, 754 F.2d at 407-08.

Plaintiffs have failed to show that adverse selection, the prudent buyer policy, or HealthMate have threatened loss or damage to their business or property because of violations of the antitrust laws for the reasons heretofore stated. Therefore, Plaintiffs' motion for a permanent injunction against prudent buyer policy and HealthMate is denied.

With respect to the Defendant's counterclaim for injunctive relief, it is premature. There is no evidence that the Plaintiff-Intervenors or their officers, directors, agents, or employees engaged in any illegal practice. Furthermore, there is no evidence that the Physicians and Surgeon Association of Rhode Island negotiated or attempted to negotiate collectively with Blue Cross concerning physicians' fees. Thus, Defendant's motion for a permanent injunction against the Plaintiff-Intervenors is denied.

DECLARATORY RELIEF

Plaintiffs also seek a declaratory judgment against the alleged acts which violate the Sherman Act. Defendant seeks a declaratory judgment against the Plaintiff-Intervenors from collectively negotiating fees to be paid by Blue Cross. The nature of the parties' claims is equitable. In light of the Court's previous ruling on the equitable claims, the Court denies declaratory relief to Plaintiffs and Defendant.

CONCLUSION

Defendant's motion for judgment notwithstanding the verdict is granted on both the antitrust claims and the interference with contractual relationships claims. Defendant's motion for a new trial is granted on the claims of intentional interference with contractual relationships. Plaintiffs' motion for additur is denied because there is no antitrust violation. Plaintiffs' motion for a permanent injunction against the prudent buyer program and HealthMate is denied because Plaintiffs' failure to show a prospective injury. The Defendant's counterclaim against the Plaintiff-Intervenors is denied because it is premature.

APPENDIX D

**UNITED STATES DISTRICT COURT
JUDICIAL DISTRICT OF RHODE ISLAND**

Case Number 86-0598B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al*

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

JUDGMENT IN A CIVIL CASE

- Jury Verdict. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.
- Decision by Court. This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED that judgment is entered for the defendant, Blue Cross and Blue Shield of Rhode Island in accordance with the Court's opinion dated July 27, 1988.

Date July 28, 1988

/s/ Lorraine Kizer
(By Deputy Clerk)

UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

Case Number 86-0598 B

OCEAN STATE PHYSICIANS HEALTH PLAN, INC.

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

VERDICT

WE, THE JURY, FIND:

- I. as to plaintiffs' Sec. 2 claim; Guilty. No Damages
- II. as to plaintiffs' claim of interference with contractual relationship; Guilty

Compensatory Damages	\$947,000.00
Punitive Damages	250,000.00

/s/ Lucien E Watters
Foreperson's Signature

24 October 1987
Date

UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

Case Number: 86-8598 B

ANTHONY J. KAZLAUSKAS and JEFFREY C. WINTERS on
behalf of physicians who had contracts with OCEAN
STATE PHYSICIANS HEALTH PLAN, INC. on APRIL 2, 1987

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND

VERDICT

WE, THE JURY, FIND:

- I. as to plaintiff's Sec. 2 claim; Guilty. No [illegible]
- II. as to plaintiffs' claim for interference with contractual relationships; Guilty

Compensatory Damages \$1,776,437.00

/s/ Lucien E Watters
Foreperson's Signature

24 October 1987
Date

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE FIRST CIRCUIT

No. 88-1851

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Plaintiffs, Appellants,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Defendant, Appellee.

Before

Campbell, *Chief Judge*,

Bownes, Breyer, Torruella, Selya* *Circuit Judges*,
and Caffrey** *Senior District Judge*.

ORDER OF COURT

Entered: September 25, 1989

The panel of judges that rendered the decision in this case having voted to deny the petition for rehearing and the suggestion for the holding of a rehearing en banc having been carefully considered by the judges of the Court in regular active service and a majority of said

* Judge Selya has recused himself.

** Of the District of Massachusetts, sitting by designation.

judges not having voted to order that the appeal be heard or reheard by the Court en banc,

It is ordered that the petition for rehearing and the suggestion for rehearing en banc be denied.

By the Court:

/s/ Francis P. Scigliano
Clerk

[cc: Messrs. Gerson and Snow]

APPENDIX F

[Transcript Exchange Between Counsel
and District Court Judge 10/9/87]

* * * *

FRIDAY, OCTOBER 9, 1987

[2] . . . (JURY ABSENT)

THE COURT: At the close of the plaintiffs' case the defendant, Blue Cross/Blue Shield, has moved for a directed verdict. This action is brought by a number of plaintiffs: (1) A provider of health insurance called Ocean State; two individual physicians employed by Ocean State, a class of physicians who are described as being, having contracts with Ocean State, and a number of individual physicians.

A little history is helpful here. The genesis of today's problem started in the 1930's when apparently there was some difficulty both on the part of individuals to pay health care costs and difficulties on the part of providers, hospitals and physicians, to obtain payment for health care costs. One conjurs up the vision of the physician being paid with chickens and that sort of thing, which those who lived in that period of time know to be accurate. Indeed, some physicians didn't get chickens or anything else, they didn't get paid. So that Blue Cross and Blue Shield began some decades ago in an atmosphere that was intended to provide a means whereby people, whereby health care costs could be spread so that people could afford the costs of health care, and so those that provided the health care would be paid. A [3] commendable effort which as the years have gone by has turned from the doctor's best friend to, from what one hears from the witness stand, to be the doctor's enemy over that period of time. In the 1970's there emerged a health care system, provider system, that was able to better control the use of health care facilities and personnel by imposing a kind

of physical responsibility on those who were paying the costs and getting the benefits out of it, that is, that the so-called HMO in which, of two types, one in which the medical doctors who were providing the services were actually employees and on a salary base, and the type where the fees to a large extent were regulated by the HMO with respect to participating physicians of such a type as the latter type as Ocean State.

Another of the actors who are present in this proceeding is an organization known as RIGHA which is a type of organization where the physicians are generally employees of the organization and paid on a salary basis. Everybody seems to agree that this latter development is the wave of the future, the so-called indemnity plan, such as Blue Cross/Blue Shield have at best a limited life in terms of what is going to happen and what is happening and what will happen in the future. Against this background is a situation that might be described as the events of the [4] summer of '86 in which both Ocean State and Blue Cross found themselves in some financial straits which required some improvement. Ocean State apparently accomplished this by a change in management and by other changes a little later on after summer such as the so-called SIPS program in which there is a pool of money established for certain specialties and in which the specialists may dip in the pool until the pool runs dry at which point they get no more for their services. In July of that year there was some rather intensive, apparently, competition for one group of employees who were employed by the State of Rhode Island, approximately fifteen thousand people. That process involved a bidding process in which Blue Cross and Ocean State bid and in which for the first time emerged a plan sponsored by Blue Cross which was something of a twin of the Ocean State Plan. That plan being called HealthMate. That was for the first time offered to the state employees at that period of time. To me the somewhat staggering financial losses that Blue

Cross was suffering at that time there were a number of things, a number of programs undertaken which all came together pretty much at the same time in addition to HealthMate. Two of the other efforts were a plan called Prudent Buyer, and the third called Adverse Selection.

In and about 1982 Blue Cross and Blue Shield merged [5] and, as I indicated, RIGHA came along in 1970. RIGHA, for a substantial period of time, purchased its hospital care from Blue Cross/Blue Shield providing its own medical services but arranging for the payment of hospital costs through Blue Cross. Blue Cross, has been indicated, was the first one on the block and achieved some substantial success in terms of enrollment. Indeed, probably was the only one on the block for a long period of time. As a result today enjoys what certainly has to be characterized as the dominant share of the Rhode Island health care provider market. Blue Cross was able to negotiate favorable arrangements with all of the hospitals in the State of Rhode Island such that it enjoyed a substantial discount. In exchange for this it did a number of things that were certainly pleasing to the hospitals. It guaranteed a cash flow. It provided the money up front and it did a number of other things.

The plaintiffs in this case make essentially three claims. (1) That the defendants have violated Section 1 of the Sherman Act in two ways, a conspiracy between RIGHA and Blue Cross, and an illegal merger in October of 1982; that the defendant has violated Section 2 of the Sherman Act in that it has used market power as a monopolist in an anticompetitive fashion, and (3) that the defendant has tortiously interferred with the contracts, not of those physicians who [6] left Ocean State and had contracts with Ocean State, but of the contracts of those physicians who remained with Ocean State.

Section 1 of the Sherman Act provides that every contract, combination in the form of trusts or otherwise or conspiracy in restraint of trade or commerce among the several states or with foreign nations are declared to be

illegal. Through the years that language has come to mean that every unreasonable restraint is illegal although the word "unreasonable" doesn't appear in the language of the statute. Section 2 provides that it shall be an offense to monopolize or attempt to monopolize or combine or conspire with any other person or persons to monopolize any part of the trade or commerce among the several states. In this case it is conceded that Blue Cross' market share was not achieved through illegal means in terms of the monopolization charge. But that what has happened here is that the combination of the policies adopted by Blue Cross to meet the threat of competition from Ocean State results in an anti-competitive package which triggers the necessary response under Section 2 of the Sherman Act. At this point we're concerned only with the question of damages. The Court will later address the issue of the application for equitable relief.

With respect to the merger of Blue Cross and Blue Shield, [7] that occurred in October 1982 at a time when Ocean State was a gleam in its progenitor's eyes. On a motion for a new trial the Court is required to approach the evidence from the standpoint most favorable to the party against whom the motion is made.

Did I say "new trial"?

MR. GEARSON: Yes, Your Honor, you did.

THE COURT: On motion for directed verdict. It is not required, however, to defer the direction of a verdict because there is little bit or a scintilla of evidence. There must be some substantial evidence that supports the claim, evidence from which reasonable jurors could come to the urged conclusion, that is, that there's a violation of Sections 1 or 2 or the tort of interference with advantageous relationships. There is a total lack of any evidence in this case, a total lack of evidence, that the Blue Cross/Blue Shield merger had any anti-competitive effect on Ocean State, or indeed any of the other plaintiffs in this suit. The argument is made that the combination of RIGHA and Blue Cross was a conspiracy which

had an effect with respect to the hospitals that each dealt with, that it had the effect of causing the hospitals to make confessions that were not made to others. The record is clear, however, that [8] there were concessions made to others, not to the same extent, but there were concessions made by hospitals. Additionally this is a suit for damages and neither Ocean State nor any of the physicians involved in this case can point to any instance in which they have been damaged in any way, in any fashion by the agreement between Blue Cross and RIGHA or by the agreement between Blue Cross and the hospitals. If there was a victim, if there was a conspiracy and there was a victim, the victim was the hospital. Not Ocean State and not any of the doctors involved. That seems perfectly clear when one applies the principles that were applied by the First Circuit in *Cartel against Blue Shield* reported at 749 F.2d. 922.

So that as to the plaintiffs' Section 1 claim, the defendant's motion for a directed verdict is granted.

Now, again, there must be some issue for the jury to decide in order that the plaintiffs may avoid a directed verdict on the Section 2 claim. At this point I'm not permitted to resolve any inferences that might arise from the circumstances. It seems to me I'm required to permit the jury to decide at this point whether or not the combination of weapons that Blue Cross/Blue Shield put together in its competitive package had an anti-competitive effect, that is, whether these, the matter of health, the combination of HealthMate and Adverse Selection and the [9] Prudent Buyer policy. At this point at least it seems to me that it raises a question which more properly should be determined by a jury. With respect then to Ocean State and its Section 2 claim that motion for directed verdict is denied.

Let's take the physicians' union. The physicians' union admitted that it has no claim for damages here. So the motion is directed as to all three issues on the physicians' union.

With respect to the claims of the individual physicians and Section 2 there are a number of complications. Not the least of which is that except for one they are all employees of professional corporations. Those professional corporations are of significance. They are of substantial significance when it comes to tax considerations. They are of substantial significance when it comes to malpractice claims. They are of substantial entities when it comes to who buys a new car. They are real existing entities and they are the entities that bill Blue Cross or Ocean State or anybody else and then they pay the doctors who work for them even though the doctors may themselves own a hundred percent of the stock of the corporation. They are separate and distinct from the corporation. Here those entities have not been made party nor have there been any effort to make them parties to this litigation. What has been done [10] is that purported assignments of the professional corporation's claims have been made to the individually named plaintiff doctors, assignment of claims for damages and for injunctive relief.

The plaintiffs argue that this is a perfectly appropriate process, that this has been done before and has been approved. An examination of the authorities cited in support of that demonstrates that what has been approved in the past has been an assignment by a member of an association to the association where there is a coordination of interest between the individual and the association to press forward on an anti-trust claims. The fruitgrowers all got together and the pharmacists all got together and they assigned their claim for damages and equitable relief to the fruitgrowers association or to the pharmacists association, trade association. That's not what happened here. For instance, there has been no assignment or purported assignment to the physicians' union. What has happened is the corporation has turned around and assigned its claim to an individual. It seems to me that makes quite a difference, that it raises some

serious question as to whether or not there's any validity to that, whether or not that's so. And this is an effort to, without applying to the Court, to make parties to the litigation corporations that had never been made parties to litigations. It's an effort to amend the [11] complaint to add parties, to back into this sort of situation. It seems to me that for that reason it must fail.

Additionally there is no real evidence of damages to these physicians arising out of any of these so-called anti-competitive acts. There's no evidence that any physician lost income, none whatsoever. There's evidence that money was withheld, but there is also no argument that the withholding was illegal. No one has remotely, except for a medical doctor, no one has remotely suggested that Blue Cross didn't have the right to withhold that money under its contract and no argument was made that that's the case. So that apart from the question of whether the corporations are here there is nothing really for a jury to award damages to the physicians in this case. So that with respect to the individual physicians on the Section 2 claim the motion is—I might say on the Section 1 claim it's granted as to all of the plaintiffs. Section 2, it's denied as to Ocean State, granted as to the individually-named physicians.

A rather unique argument is made with respect to the members of the class who are physicians contracted with Ocean State that because other physicians resigned from Ocean State allegedly due to this anti-competitive package, Ocean State was drained of some resources it [12] otherwise would have been paid to those who remained contracted to Ocean State. That it seems to me is a little attenuated but at this point I am not prepared to say that it's not something the jury shouldn't decide.

Now, much of what I've said with respect to the physicians can be applied to the third issue that is here, that is, this contractual, interference with advantageous relationships. That motion is denied with respect to Ocean State, and it's denied with respect to the class of those

who are contracted with Ocean State and granted with respect to the individual physicians. All parties may have exceptions.

MR. QUINLAN: May we just ask for clarification on one point.

THE COURT: Yes.

MR. QUINLAN: On Dr. Erinakes, he is not a professional corporation.

THE COURT: No damages, no damages. You may not agree with me, but that's the ruling, all right?

MR. QUINLAN: Yes, Your Honor.

THE COURT: Are you ready to go?

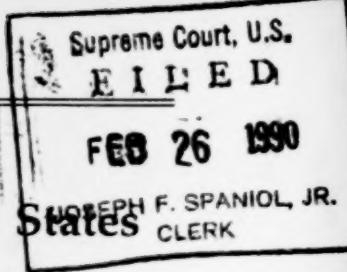
MR. SNOW: Yes, Your Honor.

MR. GEARSON: Your Honor, I believe there's a matter that Mr. Lynch would like to . . .

* * * *



In The
Supreme Court of the United States
OCTOBER TERM, 1989



OCEAN STATE PHYSICIANS HEALTH
PLAN, INC., et al.,

Petitioners,

v.

BLUE CROSS & BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari
To the United States Court of Appeals
for The First Circuit

RESPONSE OF BLUE CROSS & BLUE SHIELD
OF RHODE ISLAND TO PETITION FOR
WRIT OF CERTIORARI

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Was the Court of Appeals correct in ruling that decisions by a health insurer with lawfully acquired monopoly power not to pay higher prices that discriminated against such insurer did not violate Section 2 of the Sherman Act?
2. Was the Court of Appeals correct in ruling that health insurance programs admittedly within a state's generally applicable laws for the regulation of the business of insurance are "regulated by state law" within the meaning of the McCarran-Ferguson Act as construed by this Court in *FTC v. National Casualty Co.*, 357 U.S. 560 (1958)?
3. Does the exception to the McCarran-Ferguson Act antitrust exemption for acts of "coercion" reach all restraints of trade harmful to competition?
4. Does the decision below with respect to petitioners' claim under Rhode Island tort law raise any federal questions warranting review by this Court?

TABLE OF CONTENTS

	Page
COUNTERSTATEMENT OF QUESTIONS PRESENTED	i
TABLE OF CONTENTS	ii
TABLE OF AUTHORITIES	iii
STATEMENT OF THE CASE	1
A. The Facts	1
B. The Proceedings Below	6
SUMMARY OF ARGUMENT	9
REASONS FOR DENYING THE WRIT	11
I. THE THEORY OF NON-PRICE PREDATION WAS NOT RAISED IN THE COURT OF AP- PEALS UNTIL THE PETITION FOR REHEAR- ING AND IN ANY EVENT HAS NO APPLICABILITY TO THIS UNIQUE SET OF FACTS	11
II. THE DECISION BELOW CONCERNING THE McCARRAN-FERGUSON ACT APPLIES ES- TABLISHED PRECEDENT OF THIS COURT ...	16
III. THE DECISION BELOW CAN BE AFFIRMED ON ENTIRELY SEPARATE GROUNDS	18
IV. THE PRUDENT BUYER POLICY WAS A LEGIT- IMATE COMPETITIVE ACT WHICH CANNOT CONSTITUTE INTENTIONAL INTERFERENCE WITH CONTRACTUAL RELATIONS UNDER RHODE ISLAND TORT LAW	19
CONCLUSION	21

TABLE OF AUTHORITIES

	Page
CASES	
<i>Association of Western Railways v. Riss & Co.</i> , 299 F.2d 133 (D.C. Cir. 1962), cert. denied, 370 U.S. 916 (1962).....	18, 19
<i>Berkey Photo, Inc. v. Eastman Kodak Co.</i> , 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980).....	13
<i>California Computer Products, Inc. v. IBM Corp.</i> , 613 F.2d 727 (9th Cir. 1979).....	13
<i>County of Oneida v. Oneida Indian Nation</i> , 470 U.S. 226, 105 S.Ct. 1245, 84 L.Ed.2d 169 (1985).....	13
<i>E.I. duPont de Nemours & Co. v. Federal Trade Com- mission</i> , 729 F.2d 128 (2d Cir. 1984)	12
<i>Falls City Industries, Inc. v. Vanco Beverage, Inc.</i> , 460 U.S. 428, 103 S.Ct. 1282, 75 L.Ed.2d 174 (1983)	5
<i>FTC v. National Casualty Co.</i> , 357 U.S. 560, 78 S.Ct. 1260, 2 L.Ed.2d 1540 (1958).....	17
<i>International Brotherhood of Electrical Workers v. Hechler</i> , 481 U.S. 851, 107 S.Ct. 2161, 95 L.Ed.2d 791 (1987).....	13
<i>Kartell v. Blue Shield of Mass., Inc.</i> , 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985) . 9, 11, 12	
<i>Kosak v. United States</i> , 465 U.S. 848, 104 S.Ct. 1519, 79 L.Ed.2d 860 (1984).....	13
<i>Parker v. Brown</i> , 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943).....	17

TABLE OF AUTHORITIES - Continued

Page

Poulin Corp. v. Chrysler Corp., 861 F.2d 5 (1st Cir. 1988)..... 18

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STATUTES

McCarren-Ferguson Act

15 U.S.C. § 1012(b) *passim*

15 U.S.C. § 1013(b) *passim*

R.I. Gen. Laws § 27-19-6..... 2

R.I. Gen. Laws § 42-62-12..... 2

Sherman Act

Section 1, 15 U.S.C. § 1..... 6, 7

Section 2, 15 U.S.C. § 2 *passim*

MISCELLANEOUS

Krattenmaker & Sallop, *Anti-Competitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209 (1986) 14

In The
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RESPONSE OF BLUE CROSS & BLUE SHIELD
OF RHODE ISLAND TO PETITION FOR
WRIT OF CERTIORARI

STATEMENT OF THE CASE

A. The Facts.

In 1939, respondent Blue Cross was founded as a non-profit, charitable, hospital service corporation under Rhode Island law (J.A. 1953). Its business is to purchase health care services from physicians, hospitals, and other health care providers on behalf of its subscribers (J.A.

696), underwriting the cost of these purchases by spreading the risk of health care expenses among its subscriber groups. Blue Cross is the largest health insurer in Rhode Island, although it has suffered a steady decline in its market share in recent years (J.A. 2117).

Blue Cross' activities are regulated under Rhode Island law by the Department of Business Regulation ("DBR"). The DBR controls the prices Blue Cross charges to subscribers to ensure consistency with the public interest (R.I. Gen. Laws § 27-19-6 and § 42-62-12; J.A. 1113-1114). In addition, the DBR's regulations govern the form and substance of all contracts between Blue Cross and its subscribers.

Petitioner Ocean State is a for-profit physician-owned HMO which achieved phenomenal growth in Rhode Island, growing from 1,000 subscribers in early 1984 to nearly 90,000 subscribers by the end of 1986 (J.A. 53, J.A. 89, J.A. 2131). Like Blue Cross, Ocean State contracted with physicians to provide medical care to its subscribers, and then paid its contracted physicians on a fee-for-service basis. Unlike Blue Cross, Ocean State paid physicians only 80% of their allowed fees at the time service was rendered and withheld 20% (J.A. 1243-1244). Ocean State would pay back physicians some, all, or none of the withheld amount after year-end, dependent upon the Plan's profitability.

Ocean State's management had made a conscious decision to keep its premiums low in order to induce enrollment growth and increase market share (J.A. 1603). Ocean State's growth came largely at Blue Cross' expense. In addition, Blue Cross was experiencing serious

financial problems at that time and was forced, with the DBR's approval, to raise its premiums in order to maintain adequate reserves. As it raised its premiums, it lost more enrollees - which, in turn, forced further rate increases.

In the spring of 1986, Ocean State announced that it would not pay back any of the 20% of the fees withheld from its participating physicians for 1985 (J.A. 1949). Since Ocean State's fees approximated Blue Cross', Blue Cross realized that it was paying those physicians who participated in both plans¹ approximately 20% more than they were accepting as payment in full from Ocean State (J.A. 1949-1950). In effect, those physicians were giving Ocean State a 20% discount off the Blue Cross fees (J.A. 1182, J.A. 988).

To compete, Blue Cross adopted a number of new programs using traditional business techniques. First, it initiated a policy called "Prudent Buyer." This was nothing more than a "most favored nations" clause, which provided that Blue Cross would not pay a physician more for a service than that physician was accepting as payment in full from another buyer. Blue Cross did not insist on a price from physicians which was lower than that being paid by Ocean State or any other buyer; it merely wished to stop being the victim of price discrimination (J.A. 1967).

¹ A physician may participate in more than one health insurance program. Thus, a physician may contract with Blue Cross, with Ocean State, or with both. Petitioners' Appendix ("App.") at 2a-3a; 883 F.2d at 1103.

Accordingly, as part of the Prudent Buyer policy, Blue Cross required its participating physicians to certify that they were not accepting lower fees from other insurers than they were receiving from Blue Cross for the same service. As a result of the Prudent Buyer policy, Blue Cross "achieved significant cost savings." App. 5a; 883 F.2d at 1104. After the implementation of Prudent Buyer, approximately 350 of Ocean State's 1200 physicians resigned, at least in some cases in order to avoid a reduction in their Blue Cross fees (P.E. 204; J.A. 192-194).

Blue Cross' second competitive response was to create its own HMO "look-alike" product, called Health-Mate. HealthMate arose from a Blue Cross study which concluded that Blue Cross was losing subscribers to Ocean State because Ocean State's rates and benefit package were more attractive (J.A. 734-736). Moreover, Ocean State was specifically targeting younger and healthier people, who were better health insurance risks, through the use of a "pre-existing condition" clause (J.A. 54-55, J.A. 1166).² The result of Ocean State's targeted marketing was a phenomenon known as "adverse selection," in which the HMO insured younger and healthier low-risk subscribers (allowing lower premiums), while Blue Cross was left with an older and sicker enrollment population (requiring higher premiums to cover the correspondingly greater risk).

With the HealthMate product, Blue Cross simply matched Ocean State's marketing approach and benefit

² A pre-existing condition clause limits coverage for health conditions pre-existing the date of enrollment. Its effectiveness in deterring unhealthy applicants was established without serious opposition at trial.

package (J.A. 716-717). HealthMate was selectively marketed where there was at least a threat of another HMO offering its program to a group (J.A. 521, J.A. 831). It was used when necessary to meet competition (J.A. 831).³ Due to its own pre-existing condition clause and targeting of younger and healthier subscribers, HealthMate was offered at a price lower than the cost of traditional Blue Cross, although its rate was still higher than the Ocean State rate. App. 39a; 692 F. Supp. at 58; J.A. 94. Contrary to petitioners' suggestion (Petitioners' Brief at 5, 23 n.10), the undisputed evidence at trial was that HealthMate was sold by Blue Cross at a profit (J.A. 1125).

The third new policy adopted by Blue Cross involved "adverse selection" pricing. Because of the adverse selection Blue Cross was experiencing *vis-a-vis* Ocean State and other HMOs (whereby Blue Cross subscribers were older, sicker, and hence, more expensive), the projected health care costs for Blue Cross' standard health insurance were higher in those employer groups that offered an HMO option than in those employer groups that did not. With the approval of the DBR, Blue Cross instituted a pricing plan that took account of this projected difference in health expenses.⁴ Under this policy, employers were

³ There is nothing improper in selectively meeting competition. *See, Falls City Industries, Inc. v. Vanco Beverage, Inc.*, 460 U.S. 428, 444, 103 S.Ct. 1282, 1293, 75 L.Ed.2d 174, 192 (1983).

⁴ Blue Cross studies demonstrated that subscribers transferring from Blue Cross to an HMO that applied a "pre-existing condition" clause (such as Ocean State) utilized, on average, approximately 22% less health benefits than the pre-transfer group population (J.A. 1035-1036). Blue Cross initially adopted

(Continued on following page)

offered three different rates for traditional Blue Cross coverage. The rate was lowest for an employer who offered only traditional Blue Cross, somewhat higher for an employer who offered employees three choices - traditional Blue Cross, a competing HMO, and HealthMate (to counteract adverse selection of Blue Cross), and highest for an employer who offered a competing HMO but who declined to offer HealthMate. All three rates were computed using formulas and factors approved by the DBR (J.A. 1133).

B. Proceedings Below.

Ocean State, together with a certified class of approximately 900 physicians still under contract to provide medical services to both Blue Cross and Ocean State, brought suit against Blue Cross in the United States District Court for the District of Rhode Island. The complaint sought treble damages and injunctive relief based upon alleged violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1 and 2. Later, petitioners were granted leave to amend their complaint to add a state law claim charging Blue Cross with having intentionally interfered with Ocean State's contractual relationships with the class of physicians through implementation of the Prudent Buyer policy (J.A. 2261).

(Continued from previous page)

the adverse selection pricing policy in June, 1986 without approval from the DBR - believing that its DBR approved rating formula was sufficiently broad to permit it. The DBR disagreed and, in October, 1986, ordered Blue Cross to suspend the policy until it obtained specific approval. In November, 1986, the DBR approved Blue Cross' adverse selection rate formula, and Blue Cross resumed its use. See App. 4a n.1; 883 F.2d at 1103 n.1.

The case was tried before the Honorable Chief Judge Boyle and a jury. At the close of petitioners' case-in-chief, the district court directed a verdict in favor of Blue Cross on the Sherman Act Section 1 claims, finding a "total lack of any evidence" in support of such claims. The Sherman Act Section 2 claim and the tort claim were submitted to the jury, which found Blue Cross "guilty" of a violation of Section 2, but expressly found "no damages" to either Ocean State or the class on that claim (J.A. 31). The jury found Blue Cross "guilty" of the state law claim of intentional interference with contractual relations and awarded compensatory damages to Ocean State in the amount of \$947,000 and to the class in the amount of \$1,746,437. The jury awarded Ocean State punitive damages in the amount of \$250,000.

Blue Cross moved for entry of judgment notwithstanding the verdict, and alternatively for a new trial on the state law count. Ocean State and the class petitioned the court for entry of an injunction and for *additur*. By opinion and order dated July 27, 1988, and July 28, 1988, respectively, the district court granted judgment notwithstanding the verdict and denied petitioners' motion, finding, *inter alia*, that Blue Cross did not misuse its market power in violation of Section 2 of the Sherman Act by implementing the Prudent Buyer policy, by selectively marketing HealthMate, or by its "adverse selection" pricing. App. 67a; 692 F. Supp. at 72. The district court also found, as a matter of Rhode Island law, that Blue Cross did not unjustifiably interfere with Ocean State's contract with the class and that the jury's verdict on that count was against the clear weight of the evidence. App. 70a; 692 F. Supp. at 73. Finally, the district court ruled that

none of the challenged practices was anticompetitive, but rather that they benefited consumers and represented legitimate responses to competitive conditions. In the alternative, the district court granted Blue Cross' motion for a new trial, finding "[a] new trial is required to prevent injustice." App. 70a; 692 F. Supp. at 73.

The Court of Appeals affirmed, finding that the HealthMate and adverse selection policies were exempt from the Sherman Act under the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b). As the court reasoned in an opinion by Chief Judge Campbell, both programs qualified as the "business of insurance": HealthMate is an insurance policy which spreads the risks of policyholders; adverse selection is a pricing policy that inherently involves risk spreading. Both programs directly involve the relationship between the insurer and the insured and were, by definition, limited to entities in the "insurance industry." App. 12a-13a; 883 F.2d at 1107. The Court of Appeals also found (1) that it was "clear that both HealthMate and the adverse selection policy were 'regulated by state law.'" (App. 15a; 883 F.2d at 1108); and (2) that "adverse selection" pricing did not constitute "coercion" within the meaning of the exception to the McCarran-Ferguson exemption, holding that, in any event, Ocean State had waived the coercion argument (App. 16a n.10; 883 F.2d 1109 n.10).

With respect to the Prudent Buyer policy, the Court of Appeals found that Blue Cross' use of a most favored nations clause was not, as a matter of law, violative of Section 2 of the Sherman Act. The court noted that Blue Cross, for purposes of the appeal, did not dispute its monopoly power in a market for health care insurance in

Rhode Island. On the other hand, Ocean State conceded that Blue Cross acquired its historical advantages legitimately. The question, therefore, was whether Blue Cross maintained its lawfully acquired monopoly position through improper means. App. 18a; 883 F.2d at 1110. The court found that Blue Cross' conduct did not go beyond the needs of ordinary business dealings, beyond the ambit of ordinary business skill, and did not unnecessarily exclude competition from the health care insurance market. App. 19a; 883 F.2d at 1110. Relying upon its decision authored by Judge Breyer in *Kartell v. Blue Shield of Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985), the court noted that Blue Cross – like any purchaser of goods or services – is lawfully entitled to bargain with its providers for the best price it can get (App. 20a; 883 F.2d at 1111), and held that “[t]he antitrust laws do not prevent a purchaser from making such an obviously reasonable and obtainable price bargain with a provider.” App. 23a; 883 F.2d at 1112.

SUMMARY OF ARGUMENT

With classic hyperbole, petitioners state that the Court of Appeals has adopted a rule which shields “all exclusionary practices for which a defendant monopolist could proffer any colorable efficiency justification.” (Petitioners’ Brief at 10). This is manifestly incorrect. The court below said no such thing, holding only that a health insurer with lawfully acquired monopoly power does not violate Section 2 of the Sherman Act when it refuses to pay providers, from whom it purchases health services,

prices higher than those charged by such providers to others.

Blue Cross, notwithstanding its position as the largest health insurer in Rhode Island, was the victim of price discrimination by its physician-suppliers. Thus, this is a fact-specific case involving the unusual circumstance of price discrimination *against* a monopoly. Blue Cross responded, as would any prudent business in a like situation of competitive necessity, by declining to pay more than the price being charged by physicians to its competitor for exactly the same procedures. The Court of Appeals correctly ruled that this competitive response was not an act of monopolization.

Moreover, and most significantly, the theory of non-price predation espoused by petitioners to this Court was never raised in the Court of Appeals until the Petition for Rehearing.

With respect to the antitrust exemption provided by the McCarran-Ferguson Act, the court correctly found that Ocean State had waived any argument that Blue Cross' conduct took the form of coercion within the meaning of the McCarran-Ferguson Act by failing to mention it in its initial brief on appeal. The Court of Appeals also applied long standing precedent of this Court in finding that both HealthMate and the adverse selection policy were regulated by state law.

REASONS FOR DENYING THE WRIT

- I. THE THEORY OF NON-PRICE PREDATION WAS NOT RAISED IN THE COURT OF APPEALS UNTIL THE PETITION FOR REHEARING AND IN ANY EVENT HAS NO APPLICABILITY TO THIS UNIQUE SET OF FACTS.

In an unabashed attempt to create an issue worthy of this Court's attention when there is none, petitioners mischaracterize the theory and holding of the Court of Appeals. The court below by no means held (or even suggested) that "any colorable efficiency justification" for a monopolist's conduct (Petitioners' Brief at 10) transforms otherwise illegal exclusionary conduct into lawful conduct. Rather, the decision applied settled principles to a unique set of facts.

Despite its admitted market power in the Rhode Island health insurance market, Blue Cross found itself the victim of price discrimination by its physician-suppliers who were selling their services to a competitor for substantially less than they were charging Blue Cross. Physicians were granting Ocean State a substantial discount despite Blue Cross' position as the largest purchaser of physician services in Rhode Island. This is not a situation normally encountered in business - even in the domain of medical costs which, as Judge Breyer has described it, is "an area of great complexity where more than solely economic values are at stake." *Kartell, supra*, 749 F.2d at 931. Blue Cross' reaction to this discrimination was routine and what any properly motivated competitive

business would do; it adopted a "most favored nations" clause - a common feature in purchase-supply contracts.⁵

Instead of creating a broad rule of general application as petitioners suggest, the Court of Appeals, after reviewing the trial record, held that Blue Cross' policy of insisting upon receiving a supplier's lowest price tended to further competition on the merits, not stifle it. The court also agreed with the district court's view:

As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.

App. 19a; 883 F.2d at 1110, quoting 692 F. Supp. at 71.

This ineluctably follows from the holding of the First Circuit in *Kartell*, *supra*, 749 F.2d 922 (1st Cir. 1984), a decision which petitioners admit is correct. (Petitioners' Brief at 19). In fact, the legality of the Prudent Buyer policy rests *a fortiori* upon the holding in *Kartell*, a case where Blue Shield of Massachusetts was held to have legally limited the fees charged by physicians to subscribers; here, Blue Cross is limiting the price that *it* pays to the physicians for services it is purchasing. App. 20a; 883 F.2d at 1111.

The Court of Appeals correctly observed that Section 2 of the Sherman Act does not prohibit vigorous competition on the part of a company with lawfully acquired

⁵ Use of "most favored nations" clauses is common. See, e.g., *E.I. duPont de Nemours & Co. v. Federal Trade Commission*, 729 F.2d 128, 142 (2d Cir. 1984) (vacating an FTC order prohibiting use of "most favored nations" clauses in the sales contracts of gasoline additive manufacturers).

monopoly power. App. 18a; 883 F.2d at 1110. To the contrary, the primary purpose of the antitrust laws is to encourage competition. *See, e.g., Standard Oil Co. v. Federal Trade Commission*, 340 U.S. 231, 248-49, 71 S.Ct. 240, 249-50, 95 L.Ed. 239, 250-51 (1951). Thus, even a monopoly does not violate the Sherman Act simply by competing strenuously with its competition and by getting the rewards. *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980). A monopoly may lawfully compete, even if that competition results in injury to its competitors. *California Computer Products, Inc. v. IBM Corp.*, 613 F.2d 727, 742 (9th Cir. 1979).

Petitioners' response is that the Court of Appeals should have viewed the Prudent Buyer policy "as a classic instance of 'raising rivals' costs', a form of non-price predation." (Petitioners' Brief at 15). Petitioners, however, did not request a jury charge on "non-price predation" and the issue was not submitted to the jury. Indeed, petitioners took no exception to the Sherman Act Section 2 charge given by the district court to the jury. Rather, petitioners first articulated their theory of "non-price predation" in their Petition for Rehearing, which was denied by the Court of Appeals. Under these circumstances, any such theory has been waived and may not in the first instance be addressed in this Court. *See International Brotherhood of Electrical Workers v. Hechler*, 481 U.S. 851, 862 n.5, 107 S.Ct. 2161, 2179 n.5, 95 L.Ed.2d 791, 803 n.5 (1987); *County of Oneida v. Oneida Indian Nation*, 470 U.S. 226, 245, 105 S.Ct. 1245, 1257, 84 L.Ed.2d 169, 185 (1985); *Kosak v. United States*, 465 U.S. 848, 852 n.7, 104 S.Ct. 1519, 1523 n.7, 79 L.Ed.2d 860, 866 n.7 (1984) (the Court will not consider an argument which was not presented to the Court of Appeals).

Moreover, this theory is novel. There has been no reported district court or court of appeals decision cited by petitioners that explains the theory.⁶

In any event, the record below demonstrated not only that Ocean State did not generally increase physician fees after the implementation of Prudent Buyer, but that it did just the opposite. Ocean State's Chief Executive Officer testified that Ocean State instituted an across-the-board reduction of physician office charges and an across-the-board reduction of physician fees to a median price *after* the announcement of Blue Cross' Prudent Buyer policy (J.A. 191). Moreover, while there was testimony that Ocean State did raise some doctors' fees to keep them happy, Ocean State's Chief Financial Officer testified unequivocally that those fee increases were funded from a pool of money already committed to be paid to physicians and, accordingly, did not cost Ocean State any money (J.A. 1261). In fact, Ocean State's physician expenses as a percentage of its revenues declined significantly after implementation of Blue Cross' Prudent Buyer policy (J.A. 242).

Petitioners' other arguments concerning the Prudent Buyer policy merit no more than summary treatment.

⁶ "Raising rivals' costs" has been proposed by some scholars as a framework for addressing exclusionary vertical restraints under the antitrust laws based upon their economic effect. Krattenmaker & Sallop, *Anti-Competitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209 (1986). This theory expressly rejects this Court's prevailing jurisprudence. 96 Yale L.J. 209, 213. Moreover, even Professors Krattenmaker and Sallop admit that contested cases involving the type of restraint suggested here are "exceedingly rare." 96 Yale L.J. 209, 228.

They argue, for example, that the Court of Appeals erred in not permitting the jury to determine whether Blue Cross' response raised prices to consumers. However, pervasive state regulation of Blue Cross' rates eliminated its ability to control price. There simply was no evidence in the record, even when viewed in the light most favorable to petitioners, from which any reasonable inference could be drawn that the Prudent Buyer policy resulted in increased costs to consumers. To the contrary, the Court of Appeals, through Chief Judge Campbell, found "[a]s a result of the Prudent Buyer policy, Blue Cross achieved significant cost savings." App. 5a; 883 F.2d at 1104.

With respect to the assertion that Blue Cross had monopoly (or, more accurately, monopsony) power in a physicians services' market, Ocean State never raised the issue before the Court of Appeals. The petitioners' claim that Blue Cross had monopoly/monopsony power in a market for the purchase of physician services was not a theory presented to the jury. Further, the undisputed evidence was that Blue Cross' market share in the purchase of physician services in Rhode Island was approximately 20 to 25% – clearly insufficient to control prices or exclude competitors. (J.A. 2087-2089).

Moreover, with respect to the allegation that Blue Cross was a "monopoly broker" (Petitioners' Brief at 18, 20), this too was not raised before the Court of Appeals. The evidence was clear that there were no contractual restrictions preventing physicians from participating in as many health insurance plans as they desired. App. 3a; 883 F.2d at 1103. Theoretically at least, both Ocean State and Blue Cross could have enrolled all of the licensed physicians in Rhode Island as participants.

In short, petitioners' theory of "non-price predation" is not properly before this Court because it has been waived and has no applicability to this unique set of facts.

II. THE DECISION BELOW CONCERNING THE McCARRAN-FERGUSON ACT APPLIES ESTABLISHED PRECEDENT OF THIS COURT.

Petitioners attack the Court of Appeals' ruling concerning exempt conduct under the McCarran-Ferguson Act on two grounds. First, they invite the Court to develop a definition of "coercion" as used in the exception to the exemption. Second, they suggest the Court should revisit the standard it established long ago in interpreting the "regulated by state law" requirement of the McCarran-Ferguson Act. Neither issue warrants review.

The Court of Appeals correctly found that petitioners waived the coercion argument by failing to take exception to it in their initial brief on appeal. Since petitioners failed to argue that Blue Cross' conduct took the form of coercion within the meaning of the McCarran-Ferguson Act, the court ruled that their attempt to resurrect the argument in a reply brief was untimely. App. 16a n.10; 883 F.2d at 1109 n.10.

In any event, even the petitioners recognize the "dearth" of case law in the district and appellate courts interpreting the term "coercion" in the McCarran-Ferguson Act context. (Petitioners' Brief at 24). Petitioners urge this Court to deem an act as coercive, and hence not exempt for purposes of the McCarran-Ferguson Act, whenever economic power is used to force a result that

would not otherwise have been accomplished. Self-evidently, such a broad definition of the exception to the exemption would totally eliminate the exemption itself. "Coercion," by petitioners' definition, would be the equivalent of any restraint of trade - the very thing the Act was designed to exempt from scrutiny.

As for the second argument with respect to the McCarran-Ferguson Act, petitioners concede (Petitioners' Brief at 26) that this Court has ruled that the existence of a general regulatory scheme is sufficient to satisfy the "regulated by state law" requirement of the Act. *FTC v. National Casualty Co.*, 357 U.S. 560, 564-65, 78 S.Ct. 1260, 1262, 2 L.Ed.2d 1540, 1543 (1958). They also acknowledge the lower court teachings which follow *National Casualty Co.*, *supra*. Nevertheless, petitioners urge this Court to change this standard to the decidedly more restrictive regulatory requirement applicable to the state action doctrine. Petitioners' argument that the standards for state action immunity under *Parker v. Brown*, 317 U.S. 341, 63 S.Ct. 307, 87 L.Ed. 315 (1943), should apply to the McCarran-Ferguson Act, lacks any support. Such an interpretation would nullify Congressional intent in adopting the Act, which would have been unnecessary if it were merely duplicative of the generally applicable state action doctrine.

Thirty-two years have elapsed since this Court's pronouncement in *National Casualty Co.*, *supra*. In the meantime, Congress has taken no action to change it. Clearly, rewriting the McCarran-Ferguson Act is a job for Congress, if it is so inclined.

Finally, as an illustration of the problems which petitioners allege could occur as a result of the historical interpretation of "state regulation," they note that Blue Cross began using the adverse selection pricing formula before state approval was obtained. (Petitioners' Brief at 28). However, as the Court of Appeals correctly observed, such a lapse on Blue Cross' part has little bearing on whether the use of the adverse selection pricing was "regulated by state law." It was precisely due to the presence of a comprehensive state regulatory system that the DBR was able to order Blue Cross to suspend its use of adverse selection pricing and prohibit its resumption until after DBR approval was obtained. App. 15a n.8; 883 F.2d at 1109 n.8.

III. THE DECISION BELOW CAN BE AFFIRMED ON ENTIRELY SEPARATE GROUNDS.

Although the Court of Appeals declined to decide the issue, its decision regarding petitioners' Sherman Act Section 2 claims can be upheld on the entirely separate grounds utilized by the district court. The jury found Blue Cross "guilty" of conduct violating Section 2 of the Sherman Act, but affirmatively found "no damages" as a result of that conduct. As Chief Judge Boyle of the district court concluded, this meant that petitioners failed to establish an essential element of their proof. App. 55a; 692 F. Supp. at 66. Under these circumstances, judgment for Blue Cross was mandated. *Association of Western Railways v. Riss & Co.*, 299 F.2d 133, 136 (D.C. Cir. 1962), cert. denied, 370 U.S. 916 (1962); cf. *Poulin Corp. v. Chrysler Corp.*, 861 F.2d 5, 7 (1st Cir. 1988).

In *Riss, supra*, defendants were charged with a conspiracy to monopolize and eliminate competition in the transportation of ammunition and explosives for the United States in violation of Sections 1 and 2 of the Sherman Act. Plaintiff sued for treble damages under Section 4 of the Clayton Act. The jury returned general verdicts "for" the plaintiff but responded with the words "\$ none" as the "total amount of your verdict." The Court of Appeals correctly interpreted that verdict, which is virtually identical to the verdict in this case, as a jury finding that the alleged conspiracy had not damaged *Riss*. Noting that the "gist" of Section 4 of the Clayton Act is not merely an antitrust violation but "damage to the individual plaintiff resulting proximately from the acts of the defendant which constitute a violation of the law" (*Riss, supra*, 299 F.2d at 135), the finding meant that plaintiff had not proved its claim.

Since the jury's verdict mandated the entry of judgment for Blue Cross in any event, there is no basis for further review of the antitrust claims in this Court.

IV. THE PRUDENT BUYER POLICY WAS A LEGITIMATE COMPETITIVE ACT WHICH CANNOT CONSTITUTE INTENTIONAL INTERFERENCE WITH CONTRACTUAL RELATIONS UNDER RHODE ISLAND LAW.

Finally, petitioners urge this Court to grant certiorari to review the Court of Appeals' affirmation of the district court's analysis of admittedly "independent principles of state tort law" by Chief Judge Boyle. (Petitioners' Brief at 30). This does not raise a federal issue for this Court's consideration.

The tort theory pursued by petitioners was that the Prudent Buyer policy "interfere[d] with existing contractual relationships between plaintiff Ocean State and Class Members" (J.A. 15). However, petitioners concede that the district court correctly instructed the jury under Rhode Island law, which standard the district court then used in rendering its decision. Moreover, as the Court of Appeals noted, "[n]o other relevant tort standards have been called to our attention in the case law or otherwise." App. 27a; 883 F.2d at 1114. That being the case, petitioners cannot now challenge the lower courts' application of Rhode Island state law on this claim.

CONCLUSION

The rulings by two courts, upon reviewing the record, that respondent Blue Cross was entitled to judgment as a matter of law, do not present an important question of federal law unsettled by this Court, or one in conflict with applicable decisions of this Court, or a case otherwise calling for the supervision of the Supreme Court of the United States. Accordingly, the petition should be denied.

Respectfully submitted,

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MAR 9 1990

No. 89-1044

JOSEPH F. SPANIOL,
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,
v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals
For the First Circuit

REPLY BRIEF OF PETITIONERS OCEAN STATE
PHYSICIANS HEALTH PLAN, INC., ET AL.

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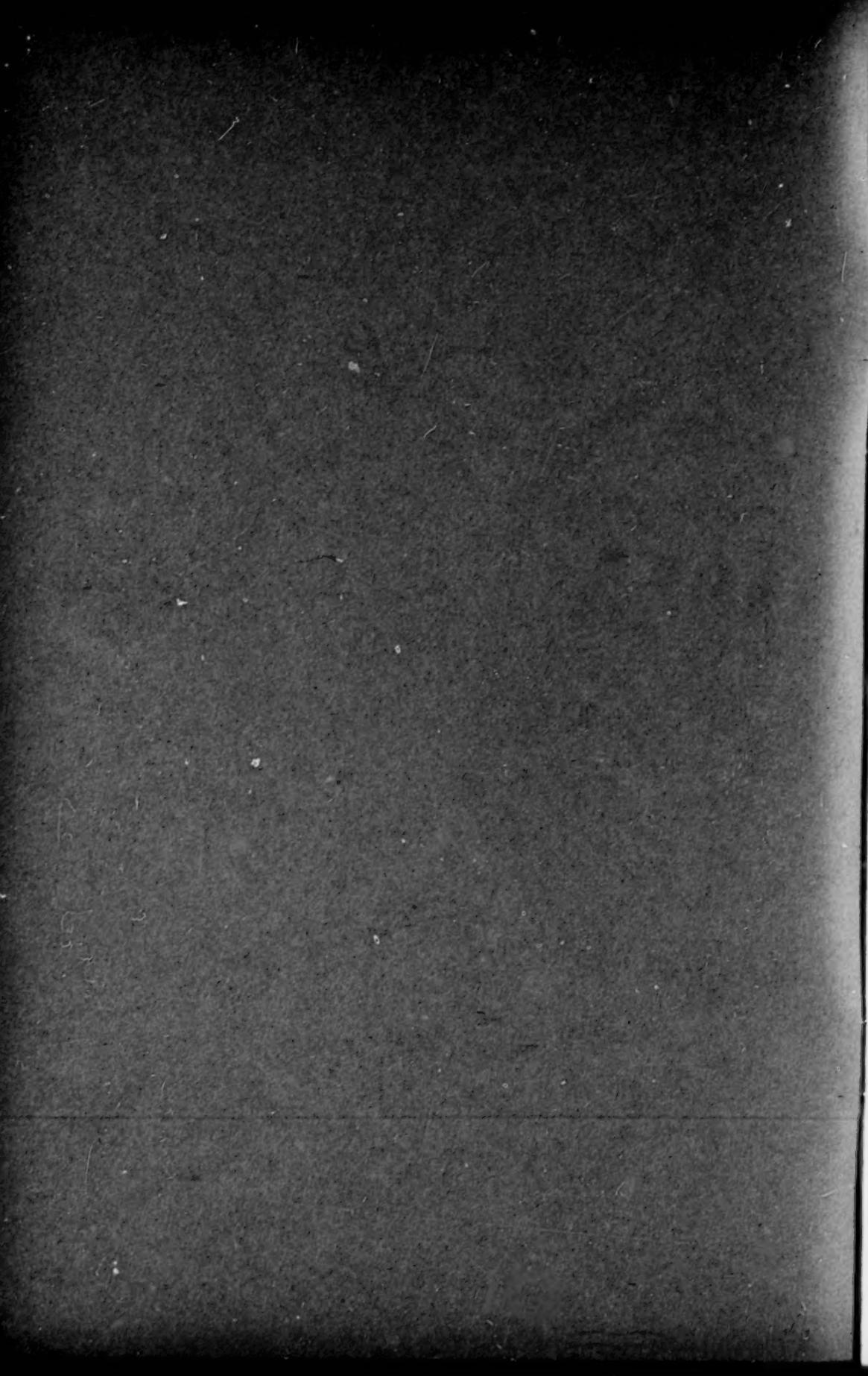


TABLE OF CONTENTS

	Page
SUMMARY	1
ARGUMENT	
This Case Involves Significant Issues of Antitrust Jurisprudence	2
The McCarran Act Should Not Bar an Examina- tion of Respondent's Conduct	9
This Court Has Authority to Review the Court of Appeals Action Regarding the State Law Claims...	10
CONCLUSION	10
APPENDIX	1a

TABLE OF AUTHORITIES

CASES	Page
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	3
<i>Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.</i> , 784 F.2d 1325 (7th Cir. 1986)	4
<i>California Retail Liquor Dealers' Ass'n v. Midcal Aluminum, Inc.</i> , 445 U.S. 97 (1980)	9
<i>Copperweld Corp. v. Independence Tube Corp.</i> , 467 U.S. 752 (1984)	3
<i>FTC v. National Casualty Co.</i> , 357 U.S. 560 (1958)	9
<i>Lorain Journal Co. v. United States</i> , 342 U.S. 143 (1951)	3
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563 (1966)	3
<i>United States v. South-Eastern Underwriters Ass'n</i> , 322 U.S. 533 (1944)	9
STATUTE	
<i>Sherman Act</i> , 15 U.S.C. § 2	<i>passim</i>
MISCELLANEOUS	
<i>Baker, Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs</i> , 14 Am. J.L. & Med. 147 (1988)	1
<i>Busey, Health Care Development</i> , 50 Antitrust L.J. 457 (1989)	1
<i>Lande, Chicago's False Foundation: Wealth Transfers (Not Just Efficiency) Should Guide Antitrust</i> , 58 Antitrust L.J. 631 (1989)	6
<i>Miller, Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?</i> , L. & Contemp. Prob., Spring 1988, at 195	1
<i>Stenger, Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?</i> , 15 Am. J.L. & Med. 111 (1989)	1

**REPLY BRIEF OF PETITIONERS OCEAN STATE
PHYSICIANS HEALTH PLAN, INC., ET AL.**

SUMMARY

Petitioners have argued that their petition for a writ of certiorari should be granted in order that this Court can provide appropriate guidance regarding the evidence necessary to support a charge of non-price predation under Section 2 of the Sherman Act. More specifically, petitioners have argued that conduct labeled as "exclusionary" by a trier of fact in a non-price predation case cannot be deemed lawful *per se* merely because such conduct seems to contribute something to economic efficiency by reducing the defendants' costs. Pet. 10-13; *see also* AMCRA Am. Br. 5-7. Additional guidance is necessary both to protect emerging competition in the market for private health insurance and to guard against proliferation of erroneous principles of antitrust jurisprudence. Pet. 16-22; *see also* AMCRA Am. Br. 4; USHC Am. Br. 6-7; GHAA Am. Br. 5-6; Kaiser Am. Br. 5-7; AMA Am. Br. 7; ADA Am. Br. 3.¹

In an attempt to minimize the significance of this case and petitioners' contentions, respondent relies on a series of specious arguments and erroneous factual assertions.² Respondent is wrong on many counts.

¹ The significant interest in this case expressed by commentators and scholars confirms its importance. *See* Busey, *Health Care Developments*, 58 Antitrust L.J. 457, 460 (1989); Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs*, 14 Am. J.L. & Med. 147 (1988); Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, L. & Contemp. Probs., Spring 1988, at 195; Stenger, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?*, 15 Am. J.L. & Med. 111 (1989).

² Respondent does not, however, contest petitioners' contentions that non-price predation involves considerations which are different from predatory pricing, and that this Court has never identified the appropriate evidentiary standard for predatory pricing cases. Pet. 12 n.10.

ARGUMENT

This Case Involves Significant Issues of Antitrust Jurisprudence

Respondent asserts that the court of appeals, after reviewing the trial record, merely determined that Blue Cross' conduct furthers competition on the merits, Br. Opp. 12, and that petitioners' challenge is barred because they "took no exception to the [district court's] Sherman Act Section 2 charge." *Id.* at 13. Reading these assertions in isolation, one would conclude the jury had found for respondent Blue Cross, not petitioners, and that having failed to object to the Court's instructions, petitioners cannot now attack the verdict. In this case, however, after being properly charged by the district court, the jury found that Blue Cross' conduct was unnecessarily restrictive of competition and "exclusionary."

There can be no doubt that the court of appeals created an unprecedented theory of *per se* legality rather than merely making a "fact-specific" determination, as respondent suggests. *Id.* at 9-10.³ Both the trial court and the court of appeals ruled that, notwithstanding the sufficiency of the evidence supporting the jury's conclusions, the conduct at issue could not be deemed "exclusionary," as a matter of law, because it may have reduced respondent's costs to some extent.⁴ In upholding respondent's

³ The trial judge himself, in denying respondent's motion for a directed verdict, recognized that the evidence was sufficient to permit the jury to determine its significance on competition. As stated by the trial court, "it seems to me I am required to permit the jury to decide at this point whether or not the combination of weapons that Blue Cross-Blue Shield put together in its competitive package had an anticompetitive effect. . . ." Pet. App. 83a.

⁴ Thus, the courts below deprived petitioners of the benefit of their proof simply because Blue Cross could point to some slight monetary savings which it derived from the operation of its "prudent buyer" policy. Indeed, it is possible that these savings, meager as they were, were more than offset by the losses which Blue Cross incurred through the initiation of its Healthmate product, which the court of appeals shielded from antitrust analysis through application of the

“prudent buyer” plan because it was conduct of a kind that normally “tends to further competition on the merits,” the court of appeals created a precedent under which any other conduct of a monopolist that on its face had a similar tendency would also be shielded from further scrutiny under Section 2. If allowed to stand, this holding could have far-reaching affects.

This Court has never held that the mere existence of some efficiency or business justification—e.g., reduced costs—is sufficient to immunize any conduct, regardless of its actual monopolistic purpose and effect. If a plausible business purpose were an absolute defense, Section 2 could be easily evaded. Indeed, virtually all mergers and joint ventures would be permissible, which is obviously not the law. *See Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752 (1984).⁵ Yet, according to the court of appeals, a monopolist’s conduct will be immunized if a colorable “business justification” or “efficiency” can be proffered. Pet. App. 19a. Under this restrictive view

McCarran-Ferguson exemption. In this regard, it is undisputed that Blue Cross did not consider Healthmate to be financially viable in the long term. J.A. 719; P.E. 77. Its purpose was merely to “save groups and increase enrollment.” *Id.* Indeed, the more people that elected the product, the more money Blue Cross would lose. App., *infra*, 3a-5a. Blue Cross erroneously claims in its response that Healthmate was sold by Blue Cross at a profit. Br. Opp. 5. However, it is clear from the transcript that the evidence was only that Healthmate was sold at a profit to a single group—the employees of the State of Rhode Island government. App., *infra*, 7a-8a. Moreover, even with regard to that single group—the State of Rhode Island employees—the combined Blue Cross products lost money. App., *infra*, 5a-6a.

⁵ Indeed, this Court had no trouble invalidating the defendant’s conduct in *United States v. Grinnell*, 384 U.S. 563 (1966), even though it involved the acquisition of other companies, presumably fostering efficiencies to some extent. Similarly, it is unlikely that the result in *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985), or *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), would have been different if the defendants had suggested some way in which their conduct helped them maximize their profits.

there would be little conduct left condemned by Section 2 except predatory pricing—and such egregious activity as arson directed at a competitor. Nevertheless, other conduct that appears on its face to be consistent with competition on the merits may turn out, on examination under the rule of reason, to be improperly exclusionary.

Raising rivals' costs has been the essence of petitioners' claim since the beginning of this case, respondent's assertions notwithstanding.⁶ Petitioners introduced evidence at trial that the goal of the "prudent buyer" policy was to use Blue Cross' purchasing power to force peti-

⁶ Petitioners' theory of the case was comprehensively set out in its briefs before the court of appeals. Thus, in its opening brief, petitioners stated (Appellants' Br. 18):

Despite its facial neutrality, the Prudent Buyer policy was designed specifically to harm Ocean State by reducing the number of Ocean State's participating physicians and increasing its costs by forcing it to pay physicians at a premium level in order to ensure that they did not terminate their participation agreements (or, ultimately, to retain non-plan doctors at additional costs) (J.A. 256, 2211a-b).

Blue Cross fully understood the effect its policy would have on Ocean State.

Similarly, in its reply brief in the court of appeals, petitioners stated (Appellants' Reply Br. 6-7):

Despite the benign face that Blue Cross would paint upon it, the jury had ample evidence before it that the Prudent Buyer policy not only was intended to injure Ocean State by depriving it of its essential competitive resource, a broad panel of participating physicians, and by increasing its costs. In practice, Prudent Buyer was applied in manner far more restrictive to competition than would have been necessary if Blue Cross' stated purpose had been its real one.

It is true, of course, that the scholarly articles regarding the "raising rivals' cost" theory are recent, but no less ardent a disciple of the Chicago School of non-interventionist economics than Judge Easterbrook has apparently recognized the legitimacy of the economic basis of the theory. *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1339-40 (7th Cir. 1986) (no proof of the market power necessary to raise rivals' costs). In any event, the "raising rivals' cost" theory is not a new legal theory, as respondent asserts, but only a characterization helpful in analyzing the potential economic consequences of certain conduct.

tioner Ocean State's physicians to resign, or to at least require Ocean State to pay more for physician services, thereby eliminating price competition in the market for physician services and obviating petitioners' cost advantage.⁷ Petitioners also introduced evidence that Blue Cross' conduct had its intended effect: there were mass defections of petitioners' contracting physicians and, in order to compensate for this loss, petitioner Ocean State had to pay more to non-contracting physicians in order to provide necessary medical care to its subscribers.⁸

As a result of Blue Cross' policies, Ocean State's enrollment ceased to grow and it lost business of some employers. Pet. 7; J.A. 65, 163-66, 585-89, 1256-57, 1268, 1426-28; P.E. 739-741, 771-772, 775. At the same time, Blue Cross was able to wipe out a substantial deficit and generate almost \$10 million in surplus, largely as a result of profitable price increases which it was able to impose. Pet. 7; J.A. 1110-13.⁹

⁷ It has been conceded in this case that Blue Cross has monopoly power. *See* Pet. App. 18a, 37a; Br. Opp. 8-9. Indeed, respondent concedes before this Court that its conduct forced petitioners' suppliers to cease doing business with petitioners. *Id.* at 4. Curiously, respondent goes on to assert that there is no evidence regarding its market power in the market for physician services, a claim which respondent did not make before the court of appeals. *Id.* at 15. Yet there can be no doubt that respondent, which had eight times the purchasing power of petitioner Ocean State, had the power to force physicians to resign from Ocean State, and, in fact, exercised that power to the detriment of Ocean State. Pet. 7.

⁸ Blue Cross' internal documents estimated these cost advantages to be worth approximately \$1.4 million per year to petitioner Ocean State. Pet. 7; J.A. 336-39; P.E. 45. Respondent erroneously asserts that the "prudent buyer" policy did not raise petitioners' costs. Br. Opp. 14. In fact, the evidence clearly showed that Ocean State incurred a debt of approximately \$500,000 in increased advertising costs. App., *infra*, 1a-2a. Moreover, Ocean State paid \$2 million to replace the services of defecting physicians. App., *infra*, 2a-3a. The fact that Ocean State was able to offset at least some of these additional costs through other savings is irrelevant. J.A. 1443.

⁹ Again, Blue Cross wrongly asserts that there was no evidence of higher prices to consumers. Br. Opp. 15. However, the record

Despite respondent's claim and the assumption of the court of appeals, cost savings were not the real goal of Blue Cross' "prudent buyer" policy.¹⁰ The evidence established that Blue Cross made no initial estimates of the savings which its "prudent buyer" policy would achieve, and in fact did not introduce the policy to achieve savings. J.A. 336-37, 350-51. Rather, Blue Cross actually minimized any potential cost savings by changing the implementation date of its "prudent buyer" policy to give physicians adequate time to resign from Ocean State. J.A. 852-55, 1220-22, 1227-31. Moreover, Blue Cross undertook a campaign designed to notify physicians of the date by which resignations had to be submitted to petitioner Ocean State because "Blue Cross didn't have the luxury of waiting another year for Ocean State's physicians to resign." P.E. 45.

Nor can there be any doubt that respondent engaged in this conduct willfully. As the court of appeals recognized, the purpose of Blue Cross' policy was to castrate Ocean State, and Blue Cross officials stated, that "not one guy in the state isn't going to know the implications of signing with Ocean State." Pet. App. 24a. Indeed, the court of appeals conceded that "the jury may reasonably have concluded . . . , that Blue Cross' leadership desired to put Ocean State out of business." *Id.*¹¹

clearly shows that as a result of policies challenged by petitioners, Blue Cross was able to profitably raise prices. App., *infra*, 6a-7a.

¹⁰ It is, therefore, not surprising that actual savings were de minimis—approximately one-half of one percent of Blue Cross' total private health insurance payments. Pet. 7; J.A. 1232; P.E. 640. Although this reduction in payments to physicians is only a wealth transfer, it might be construed to represent what economists term a "productive efficiency." Lande, *Chicago's False Foundation: Wealth Transfers (Not Just Efficiency) Should Guide Antitrust*, 58 Antitrust L.J. 631, 634 (1989). However, to the extent that the conduct also increased market power so that Blue Cross could increase premiums as it did here, Pet. 7, the conduct also creates an "allocative inefficiency." *Id.* Such inefficiencies must be weighed against any "productive efficiency"—here a minimal benefit even if consumers had realized it.

¹¹ Unlike other "subjective evidence" which can be consistent with aggressive competition—e.g., "let's get more business"—Blue Cross'

Respondent's argument that it is the victim of price discrimination, which was not made to the court of appeals, nonetheless has been anticipated by amicus AMCRA. In the amicus' words, such a claim by a purchaser with market power is "patently absurd." AMCRA Am. Br. 15. By definition, such a purchaser has the power to demand the best price from its suppliers, if it chooses, and to obtain that price without punishing suppliers for dealing with competitors. Amicus AMCRA astutely observes that what respondent calls "the unusual circumstance of price discrimination *against* a monopoly" should be a red flag indicating that Blue Cross was not really interested in low input prices at all but was instead interested in preventing physicians from marketing themselves through any other outlet. Amicus' account of Blue Cross' monopolistic strategy suggests, at least, that the court of appeals was wrong to resolve the case on the basis of its own assumptions concerning Blue Cross' motives and business objectives.

In any event, whether or not Blue Cross could have negotiated better prices from its physicians is beside the point, as amicus curiae Group Health Association of America, Inc. correctly observes. GHA Am. Br. 14-16. To the extent that physicians were already providing services to Blue Cross at the physicians' marginal costs, then the threatened 20% reduction imposed by Blue Cross would force those physicians to provide their services below cost—unless they resigned from Ocean State. Conversely, if Blue Cross was, in fact, sharing its monopoly profits with physicians, as both petitioners and amicus AMCRA have argued, then reducing fees 20% only to physicians who continued to do business with its rival was hardly the most efficient or least restrictive way to achieve cost savings. Pet. 18-22; AMCRA Am. Br. 13-18.

The simple truth is that Blue Cross didn't know and didn't care whether its policy required physicians to

statements in this case clearly evidence an intent to harm Ocean State through the exercise of its market power.

sell below cost. Given its market power, Blue Cross' conduct could have no result other than the one that in fact occurred: a substantial number of petitioner Ocean State's physicians defected, and as a result, petitioner had to increase its payments to physicians.¹²

There can be no question that further guidance is necessary in order to insure that the courts use appropriate antitrust analysis. Indeed, even the trial judge in this case noted:

What is anti-competitive activity is not a matter that has been clearly defined. There are some significant signposts along the way, but the route is not so clearly marked that departures are unavoidable.

Pet. App. 62a. It is this Court's responsibility to provide the kind of clearly marked signposts that will prevent monopolists from maintaining their monopoly power through non-price predation in ways that create harm to consumers through higher prices. Otherwise, monopolists will be free to exert their economic power free of any fear of challenge simply by establishing a possible "efficiency" or "business" justification. Indeed, there is reason to believe this is already happening in the health insurance industry.¹³ GHAA Am. Br. 4-5; Kaiser Am. Br. 4-5; USHC Am. Br. 13-14.

¹² This fact demonstrates the fallacy of the "below incremental cost" test imposed by the court of appeals. Pet. App. 19a-20a. Whether or not, by reducing fees to Ocean State physicians by 20%, Blue Cross was forcing those physicians to sell below their costs, the economic effect of the policy would be to drive many physicians out of Ocean State given the disparity in purchasing power between Ocean State and Blue Cross. In addition, the court of appeals' test imposes an impossible burden on a plaintiff—i.e., establishing the cost of production of each of the 1200 Ocean State physicians.

¹³ Respondents also argue that the court of appeals' opinion can be affirmed on separate grounds—i.e., the jury did not allocate the damages to the antitrust claim. Br. Opp. 18-19. The simple answer to this claim is that the court of appeals' decision does not rest on that rationale. Pet. App. 8a-11a.

The McCarran Act Should Not Bar an Examination of Respondent's Conduct

Respondent states that the McCarran Act "would have been unnecessary if it were merely duplicative of the generally applicable state action doctrine." Br. Opp. 17. But when the McCarran exemption was passed and even when it was first construed to require only the existence of a general regulatory scheme in *FTC v. National Casualty Co.*, 357 U.S. 560, 564-65 (1958), the state action doctrine had not taken its current form. Indeed, the requirement of active state supervision was finally clarified only in the 1980 decision in *California Retail Liquor Dealers' Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 104-06 (1980). Surely the implied immunity for actively regulated insurer conduct was not so clear in 1945 that the McCarran exemption must be deemed, simply because it is explicit, to exempt conduct that the implied exemption does not cover. After all, the "state action" immunity that was subsequently found implicit in the Sherman Act is based on the same concerns regarding federalism that appeared when state regulation of the business of insurance was threatened by *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 562 (1944).¹⁴

¹⁴ In immunizing respondent's "adverse selection" factors and Healthmate product, the court of appeals displayed a remarkable tolerance for conduct designed, not to enhance efficiencies, but to destroy a competitor through the willful exercise of market power. Thus, the Court failed to analyze the consequences of the "adverse selection" factors—which permitted respondent to manipulate actuarial calculations in order to use its market power to discourage employers from doing business with petitioner Ocean State even though respondent initiated these practices without the requisite approval of the state. Moreover, the Court held that the coercion exception was not raised in a timely manner by petitioners. Yet the district court did not hold that the McCarran immunity was applicable. Pet. App. 56a. Thus, it was respondent's responsibility to raise the issue on appeal. Petitioners were, therefore, timely in arguing in their reply brief that the "coercion" exception applied. Similarly, the court of appeals held that McCarran immunized the marketing of the Healthmate product—characterized by Blue Cross itself as losing money in direct proportion to its use (App., *infra*, 5a)—even

**This Court Has Authority to Review the Court of Appeals
Action Regarding the State Law Claims**

Finally, respondent argues that this Court cannot review the court of appeals' rejection of the jury's damages award rendered on the tortious interference claim because that claim is grounded in state law. Br. Op. 19-20. As respondent concedes, after being appropriately charged regarding the elements of the state law claim, the jury found substantial damages for petitioner Ocean State, and its class of physicians. The court of appeals nevertheless disregarded that verdict, holding—without benefit of any citations to Rhode Island case law—that the conduct at issue could not be violative of state law unless it was also "exclusionary" under federal antitrust law. Respondent now apparently claims that it is appropriate for the federal court of appeals to arrogate to itself a determination regarding state tort law but that it would violate accepted principles of federalism for this Court to review the appropriateness of the court of appeals' determination.

CONCLUSION

For the foregoing reasons, and for the reasons contained in the petition for a writ of certiorari, petitioners submit that the Court should grant certiorari to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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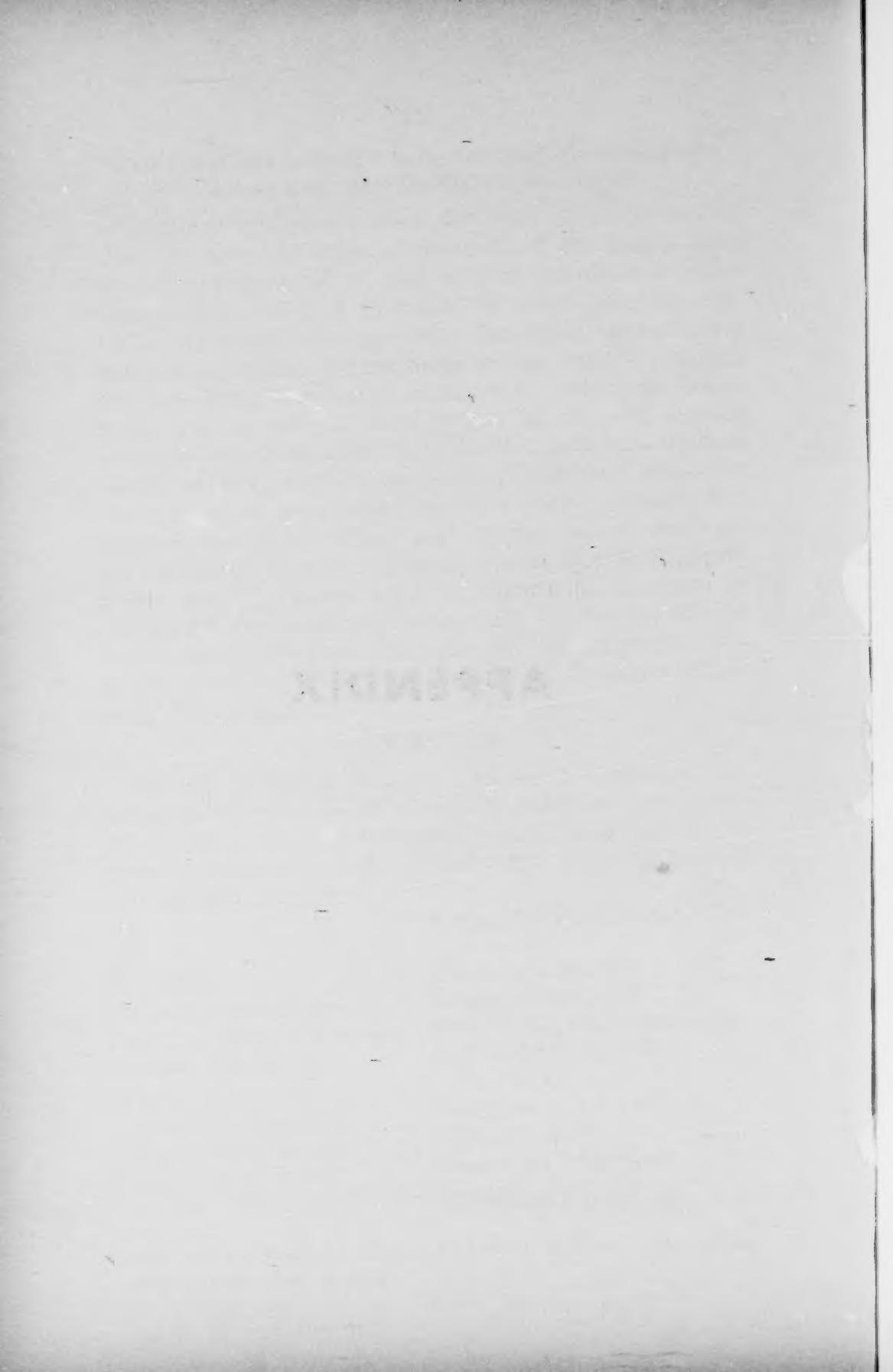
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APPENDIX



APPENDIX

I. Excerpts from the testimony of Robert Suellentrop (J.A. at 154-55):

- THE COURT: We are talking about the effect of the Prudent Buyer Plan, if any, on Ocean State.

THE WITNESS: Yes, there was a direct effect.

THE COURT: Now you tell us you had a mass disaffiliation of physicians.

THE WITNESS: Yes, Sir.

THE COURT: Now what else, if anything, happened?

THE WITNESS: The other effect is that because of the disaffiliation of physicians, we had to do something to make sure that the public understood that it was not the end of Ocean State, that we weren't going to go out of business, and so we had to have a significant advertising and public relations campaign.

THE COURT: You had P.R. campaign, right?

THE WITNESS: Yes, Sir, a significant one.

Q How much did it cost?

A In total we spent about two hundred thousand dollars in that fourth quarter when we would not—

THE COURT: That was just on this business of this mass disaffiliation or was it on something else?

THE WITNESS: It was the advertising and public relations campaign that was developed to specifically address that issue and was developed with the assistance of Duffy & Shanley Advertising Firm.

Q Would this campaign have been undertaken if not for the imposition of the Prudent Buyer?

A No, sir.

J.A. at 168-69:

Q And as to 1987, what does that show?

A Six hundred thirty-five thousand dollars is being budgeted and will be spent in 1987 on advertising expenses.

Q To what extent, if any, do you relate that to Prudent Buyer?

A I relate it to about three hundred and thirty-five thousand dollars worth. The industry average indicates that IPA models of our size will be spending over two hundred thousand dollars this year on advertising expenses. I would say that three hundred thousand dollars is a more realistic target but we have had to spend twice that much because of the activities that have taken place.

J.A. at 181-82:

Q What experience in 1987 did you look at?

A We looked at what we actually have paid per service for those four specialties of orthopedics, anesthesiology, surgery—I forgot one; anesthesiology, orthopedics, surgery and radiology, and compared that with what we expected in the budget to pay for those services.

Q And what is the difference?

MR. SNOW: Objection.

THE COURT: Just a moment. I will allow the question.

What is the difference between the actual and the budget figure?

THE WITNESS: Approximately two million dollars.

Q Did Ocean State experience in 1986 any additional costs as to contracting physicians?

A The year again?

Q 1986.

A I need you to repeat the question.

Q Was there any change within 1986 or any addition in 1986 to budgeted costs for contracting physicians?

A We had to make some adjustments in November of 1987 but I don't have a specific dollar—

Q You said 1987.

A November, 1986 but I do not have a specific amount.

Q Did you have to make any changes as to 1987 in cost for contracting physicians?

A Yes, sir.

Q And what changes, if any, did you make?

A We had to enter into special contractual arrangements to either pay bill charges or match another fee schedule for those four specialties in particular.

Q And what was the total cost of that change?

A Approximately two million dollars.

J.A. at 255-56:

Q Now obstetricians who did disaffiliate or indicate an intention to disaffiliate from Ocean State, did you bring back or retain any of them?

A Of those physicians who in the fall of 1986, of those physicians who indicated that they were intending to disaffiliate, yes, we did bring some back and they withdrew their intention to disaffiliate—

Q Was anything—

A Others did not.

Q Excuse me. I didn't mean to interrupt you. Did you finish your answer?

A Some other physicians, obstetricians, did not withdraw their intention to disaffiliate and did in fact do so.

Q As to the ones who did withdraw their intentions to disaffiliate and stayed or came back, were any changes made as to their renumeration [sic]?

A To those physicians who decided to stay with us?

Q Yes.

A We did adjust the fee profile for about sixteen different procedures, normal vaginal deliveries being one, and about thirteen or fourteen GYN procedures. There was a payment issue that was of real concern to them and we adjusted to that.

II. Excerpts from the testimony of Raymond Baedeker (J.A. at 1091-94):

Q The HealthMate program was only going to be offered selectively where Ocean State was a threat to the Blue Cross standard plan, isn't that fair?

A That's correct.

Q And before you put the HealthMate product on the market with the State of Rhode Island on July 1, '86, did you estimate the savings and losses that you would have from HealthMate prior to July 1 of '86?

A No, we did not.

Q And do you usually make such estimates before you introduce a new product into the market?

THE COURT: What do you mean by "savings"?

Q I'm sorry, I meant did you estimate what you thought the product would make or lose for you before you introduced it into the market?

A We did not.

Q Do you usually make such estimates of profits or losses of a new product before you introduce them into the market?

A Not necessarily.

Q I said do you usually.

A Very often we do.

Q But you didn't in this case?

A We did not.

Q Can you tell us why you didn't make such estimates with regard to HealthMate?

A We didn't feel that that was necessary. This was a product that we felt was necessary to put on the market.

Q It was necessary to put it on the market?

A That's correct.

Q Can you take a look at Page 2 of this integrated rating policy that's part of Attachment 37. We put up a transparency there. At the bottom of this page after it says "financial analysis," there's some estimates of the impact of certain numbers of transfers to the HealthMate product, is there not?

A Yes.

Q And if you look at the column on your left, it says "actual transfers to plus 15%" and as I read across if you got 15% of the enrollment in the plus product, you would break even, is that true?

A That's true.

Q And that's whether or not the standard rates were set the same as the plus rates or set at 5% below, correct?

A That's correct.

Q And you had that option as to where to set the two rates?

A Yes.

Q And that was done on the basis of what marketing thought made sense from a marketing standpoint?

A That's correct.

Q But under either case if you got 15% of the population of plus, you'd break even. I take it, it's not shown there, but if you got 5% or 10% of the population, I take it you'd make money?

A That is also correct.

Q But if you got 20% you started to lose money under those estimated, don't you?

A That's correct.

Q And the more people you get in the program, the more money you lose, right?

A Yes.

J.A. at 1096:

Q Do you know whether in fact for that year, that is, the year beginning July 1, of '86 Blue Cross lost money on the contract with the state, total contract with the state?

A When you define the total contract of the state, are you including HealthMate?

Q I'm including both together, basic Blue and Health-Mate, the contract was for both, wasn't it?

A Yes.

THE COURT: Either.

THE WITNESS: The answer is yes.

Q You did?

A In total.

Q Yes, and was that amount about \$2,500,000?

A I don't recall the amount.

Q Do you know whether that amount was in fact substantially greater than the loss the year before when you had not had HealthMate?

A I don't recall those amounts.

Q You don't know that?

A I do not.

J.A. at 1110-12:

Q So that for the year '85 and the first two quarters of '86, we're talking about a loss of what, 12,000,000, and another thirteen or so million for the first two quarters?

A Yes.

Q Take a look at Plaintiff's Exhibit 369. I'm sorry, again I missed one, take a look at 112 first. This is the quarterly report for the last quarter of '86, do you see that again on the second page?

A I do.

Q And that shows again in the last quarter of '86 of 7,670,434, you see that?

A I do.

Q And that's for experience rated groups?

A That's correct.

Q And now take a look lastly at 369, you see that second page?

A I do.

Q And that one is for the first quarter of '87, isn't it?

A That is the first quarter of '87.

Q And that shows a gain in experience rated groups for 2,206,870, correct?

A That is correct.

Q So the picture is that from losing a lot of money in experience rated groups in '85 and the first two quarters in '86, by the last quarter of '86 and the first quarter of '87 you were making a lot of money on experience rated groups, you were at least making money?

A We were making money.

Q And that is a significant turnaround, isn't it?

A It is a turnaround.

Q And isn't the reason for that turnaround that basically that you started increasing your rates?

A That is a part of the reason.

Q Is it a significant part of the reason?

A I'm not sure about the reference to significant. It is an important part of the reason.

J.A. at 1124-26:

Q What group was HealthMate offered to first?

A The State of Rhode Island employee group.

Q You testified on your direct examination that no estimate was made of what HealthMate would make or lose before it was marketed, could you tell me why that was done for HealthMate specifically?

A That was not done because we didn't really feel the need to do it. We knew it was a product that had to be, in our view, had to be placed on the market. So we went ahead and developed the product and rated it.

Q What was happening with Blue Cross' HMO Rhode Island at that time?

A At that time we were waiting for approval to operate HMO Rhode Island.

Q Had that request for approval been filed for some time before the Department of Business Regulations?

A Yes.

Q Have you recently received any preliminary results with respect to how HealthMate did in the State of Rhode Island over its first 12-month period?

A Yes.

Q And what are they?

A Unfortunately I don't recall the amount of money, however, it was a gain. A gain in the sense of income was in excess of claims expense.

Q And is that gain used to offset losses in other areas?

A Yes.

Q Have you, Blue Cross, been marketing HealthMate to other employee groups?

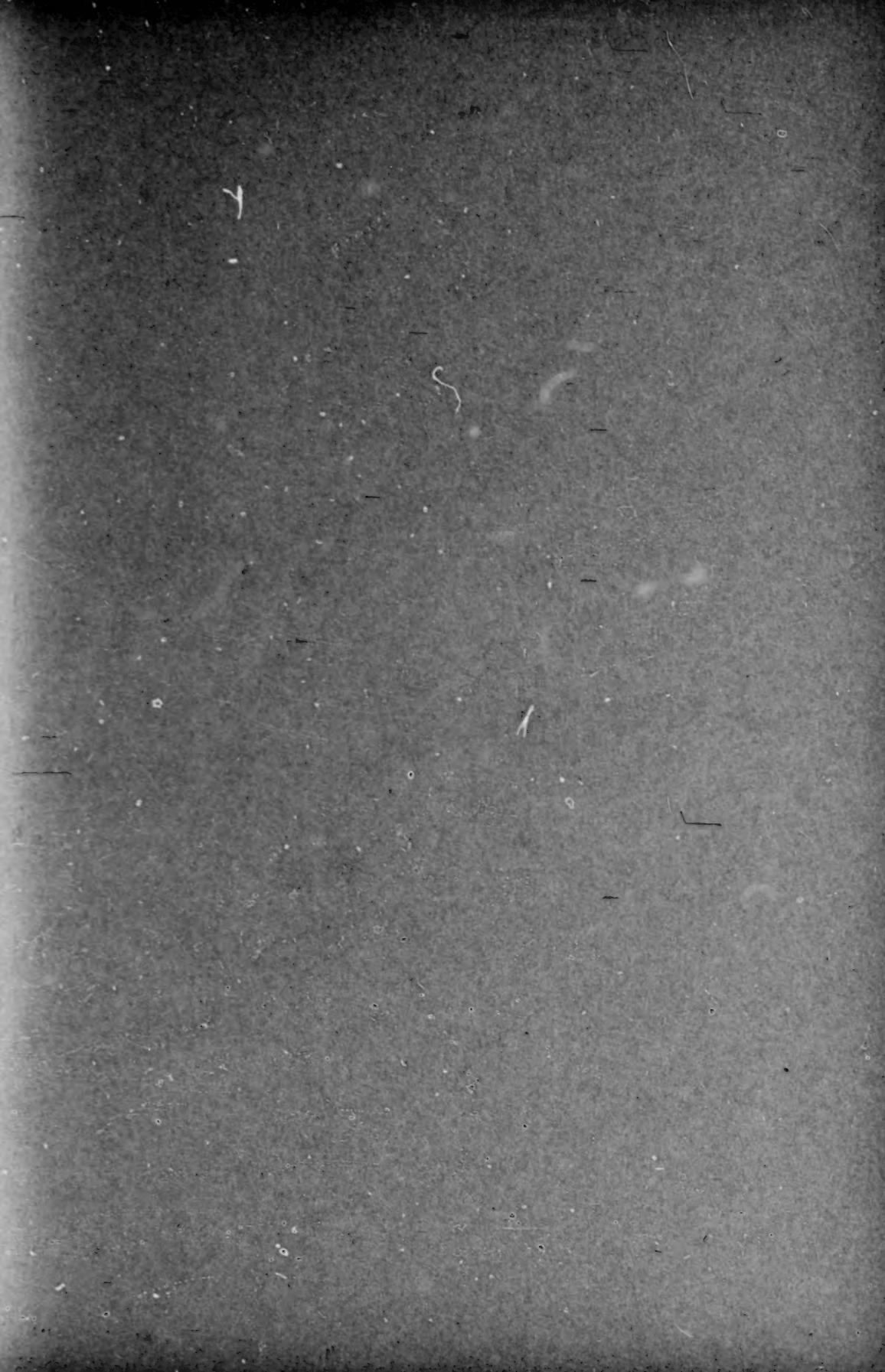
A Yes.

Q What kind of groups?

A Groups in Class IER.

Q Have you received any results yet from these groups as to whether HealthMate operated at a gain or a loss?

A I have not.



IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,
v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the First Circuit

**BRIEF OF KAISER FOUNDATION HEALTH PLAN, INC.
AS AMICUS CURIAE
IN SUPPORT OF THE PETITIONERS**

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICUS CURIAE	1
REASONS FOR GRANTING THE WRIT	5
I. INTRODUCTION	5
II. THE COURT BELOW SANCTIONED A PARADIGM FOR MONOPOLIZATION AND FAILED TO UNDERSTAND THE POWER OF THE MONOPOLIST	7
A. "Prudent Buyer"	8
B. "HealthMate"	10
C. Adverse Selection	10
CONCLUSION	14

TABLE OF AUTHORITIES

	Page
CASES	
<i>Continental Ore Co. v. Union Carbide & Carbon Corp.</i> , 370 U.S. 690 (1962)	13
<i>Ocean State Physicians Health Plan v. Blue Cross</i> , 883 F.2d 1101 (1st Cir. 1989)	<i>passim</i>
<i>United States Navigation Co. v. Cunard S.S. Co.</i> , 284 U.S. 474 (1932)	12
<i>United States v. Patten</i> , 226 U.S. 525 (1913)	13
STATUTES	
<i>McCarran-Ferguson Act</i> , 15 U.S.C. § 1013	<i>passim</i>
<i>Sherman Act</i> , 15 U.S.C. § 2	<i>passim</i>
<i>I.R.C. § 501(c) (3)</i>	2
PERIODICALS	
Frances C. Cunningham, and John W. Williamson, M.D., <i>How does the Quality of Health Care in HMOs Compare to that in Other Settings?: An Analytic Literature Review: 1958 to 1979</i> , <i>The Group Health Journal</i> , Winter 1980	3
Harold S. Luft, Ph.D., <i>HMO Performance: Current Knowledge and Questions for the 1980s, A Research Agenda Considered</i> , <i>The Group Health Journal</i> , Winter 1980	3
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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

No. 89-1044

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
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v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

**On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the First Circuit**

**BRIEF OF KAISER FOUNDATION HEALTH PLAN, INC.
AS AMICUS CURIAE
IN SUPPORT OF THE PETITIONERS**

INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Kaiser Foundation Health Plan, Inc. ("Kaiser") files this brief as *amicus curiae* in support of the petition for writ of certiorari.¹

¹ Letters of consent from both parties have been lodged with the Clerk of the Court.

Kaiser is in the business of providing health care services, although in a different way than either the petitioner or the respondent. The Court of Appeals' opinion blesses a blueprint for monopolization in an important segment of the health care industry. Because of the dominance of Blue Cross-type plans in many markets, that pattern can easily be copied, through much of the nation, with devastating effect on incipient competition in the financing and delivery of health care services. Specifically, in markets that Kaiser participates in, Kaiser could easily be victimized by the same type of scheme that victimized Ocean State here.

Kaiser and its 11 principal subsidiaries are part of a group practice prepayment program often called "Kaiser Permanente," a term that identifies a number of organizations and the health care program that they conduct. Through its Health Plans, Kaiser enrolls members under agreements that require the contracting Health Plan to arrange or provide comprehensive prepaid health care services for its enrolled members. Kaiser arranges these services through other Kaiser Permanente organizations —Kaiser Foundation Hospitals and the Permanente Medical Groups. Health Plans and Hospitals are charitable organizations under I.R.C. § 501(c)(3). Health Plans are prototypical of comprehensive group practice prepayment plans, sometimes called "Kaiser-type" plans.

Kaiser represents one type of "non-traditional" health care program; its Health Plans assume responsibility for organizing and providing health care, not simply insuring its cost. Kaiser operates at both the insurer and provider levels, competing successfully on price with Blue Cross and the health insurance industry generally because of the cost savings effected at the provider level. These savings are real, because they result principally from appropriate utilization of health services (*e.g.*, where medically appropriate, the substitution of less expensive outpatient surgery for more expensive inpatient surgery). It is generally accepted that group practice

prepayment plans such as Kaiser provide care of equal or superior quality at lower cost than traditional indemnity programs that pay providers their fee-for-service charges.²

By contrast, the "traditional" form of a health care plan is the indemnity plan, typified by Blue Cross and Blue Shield of Rhode Island, that simply reimburses the cost (or part of the cost) of care. Under the traditional approach, the insurer serves essentially as a conduit that passes through to policyholders (in the form of premiums) the charges of providers—principally physicians and hospitals.

Some people, and a subset of nearly every employer group with whom Kaiser does business, demand freedom to choose from physicians not affiliated with a particular system. For this reason, among others, Kaiser developed the dual choice (or multiple choice) concept under which Kaiser normally will not participate in an employer's health benefits program unless eligible employees are provided a choice from among one or more other plans that do not limit choice of physician. The dual choice principle ultimately was incorporated as part of the Federal Employees Health Benefits Program, even though this program, as originally proposed, would have been conducted as a single nationwide indemnity plan. Under dual choice and multiple choice plans, federal employees, and many millions of other employees throughout the country, and their families, have the opportunity to

² Frances C. Cunningham, and John W. Williamson, M.D., *How does the Quality of Health Care in HMOs Compare to that in Other Settings?: An Analytic Literature Review: 1958 to 1979*, The Group Health Journal, Winter 1980, P. 4; Harold S. Luft, Ph.D., *HMO Performance: Current Knowledge and Questions for the 1980s, A Research Agenda Considered*, The Group Health Journal, Winter 1980, P. 34; Willard G. Manning, Ph.D., et al., *A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services*, The New England Journal of Medicine, June 7, 1984, Vol. 310, Number 23, P. 1505.

choose from among significantly different approaches to financing and delivering health care.

Kaiser-type plans offer an alternative form of health care financing and delivery arrangement that would, if not thwarted by the exclusionary practices of a dominant indemnity plan, create active price, quality and product competition in the provision of health care services. Thus, there is every incentive for the dominant provider to nip their growth in the bud, before the alternative plans can grow to sufficient size to compete effectively. In this case, Blue Cross' market power was used to quash a developing HMO in Rhode Island. But it could just as easily be adapted to limit the growth of a Kaiser-type plan, virtually anywhere in the country.

Specifically, traditional indemnity plans of the Blue Cross-type are either (1) refusing with increasing frequency to contract with an employer if the employer offers Kaiser or another competing health care plan to its employees, or (2) imposing higher premiums for their traditional health benefits coverage—which many employers feel they “must” carry in order to offer unlimited “choice of physician”—unless the employer drops competing plans. Some traditional plans refuse to provide coverage to an employer group unless the competing plan’s membership is frozen at current membership levels—resulting in no new members for the competing plan while the members it retains become older and sicker (and thus more costly to care for). These and similar tactics, virtually unheard of three years ago, place increasing pressure on employers to exclude competing health plans and have made them less attractive to employees. Thus, the opinion below, which insulates these tactics from antitrust scrutiny, threatens development of alternative methods of delivering health care services, and Kaiser’s ability to compete and grow.

Plans such as Kaiser, irrespective of their financial strength, are particularly vulnerable if traditional plans

such as Blue Cross that offer unlimited choice of physician are permitted to engage in exclusionary practices like those sanctioned by the Court of Appeals. Because employers prefer to offer at least one plan that has unlimited choice of physician, most employers are unable to resist insurers' exclusionary demands. Indeed, if a traditional indemnity plan with unlimited choice of physician pressures an employer by threatening to cancel coverage unless the employer drops a competing Kaiser-type plan, employers will almost always drop the competing plan and retain the traditional indemnity plan because at least some of most employers' employees demand unlimited choice of physician.

Accordingly, as the principal offeror of "Kaiser-type" plans, Kaiser submits this *amicus curiae* brief in support of the writ of certiorari in order to highlight (1) the breadth and importance of this case, and (2) the respect in which the opinion below authorizes the exercise and maintenance of monopoly power.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case presents two closely related issues about the abuse of monopoly power. *First*, it presents an important issue about the monopolist's use of monopoly power to impose higher costs on, or reduce supply to, incipient competition. *Second*, the case presents the related question whether the use of monopoly power to impose higher prices on those who must purchase the monopolist's services, unless that purchaser ceases dealing with a competitor—ordinarily regarded as "coercive" under the Sherman Act, 15 U.S.C. § 2—constitutes "coercion" under the McCarran-Ferguson Act, 15 U.S.C. § 1013, as well.

The Court of Appeals' endorsement of the actions of Blue Cross of Rhode Island offers a blueprint for monopolizing an important segment of the health care industry. The practices in question were found by a properly in-

structed jury to be part of an unlawful attempt to use monopoly power to maintain a monopoly. But in important respects, the opinion below substituted incorrect and insupportable notions of economic theory for findings of both anticompetitive intent and effect by a jury.

In recent years, this Court has rarely examined the limits of permissible anticompetitive conduct by a monopolist, particularly in the context of the monopolist *purchaser* of goods or services. But if the decision below is good law, it is fair to say that virtually nothing except predatory (i.e., below-cost) pricing would constitute an unlawful attempt to maintain a monopoly. Here, under the guise of efficiency, the lower court blessed a monopolist's decision to penalize a supplier if that supplier continued to supply the monopolist's incipient competition at a lower cost. The monopolist thus used its monopoly power over the supplier to disable a new entrant in the market by limiting the new entrant's supplies and raising its costs. That strategy might be permissible for an ordinary firm, but an ordinary firm could not afford to engage in that type of strategy, or expect to succeed with it if it tried. It was, however, a strategy employed here by a monopolist, effective only by virtue of monopoly power, and designed to maintain that monopoly position.

This case also concerns the scope of the McCarran-Ferguson exemption under Section 2 of the Sherman Act, where the conduct at issue is merely one part of a larger, demonstrable scheme to monopolize. The petition squarely presents the question whether a monopolist, which uses its market power to set prices that penalize customers for purchasing services from a competitor, is employing "coercion" of the kind forbidden by the Sherman Act and thus statutorily beyond the protection of the McCarran-Ferguson Act.

The important issues about the use of monopoly power presented by this case go to the heart of Section 2 of the Sherman Act. These issues are of immediate and broad

implication in the field of health care—which now consumes nearly 12%³ of the gross national product, and where active competition is vitally needed as a restraint on burgeoning costs. It therefore presents a compelling case of both conceptual and practical importance that calls for review by this Court.

II. THE COURT BELOW SANCTIONED A PARADIGM FOR MONOPOLIZATION AND FAILED TO UNDERSTAND THE POWER OF THE MONOPOLIST

It is conceded that Blue Cross and Blue Shield of Rhode Island held monopoly power, possessing a market share of at least 80%. Blue Cross had participation contracts with nearly 2,000 physicians, more than 90% of those in the State. Because of the number of participating physicians (which gives wide choice to employees), employers have a strong incentive to become and remain participants in the Blue Cross plan. Conversely, because of the large number of employees who are members of the plan, most physicians find it necessary to serve Blue Cross members or lose out on a significant proportion of the population.

In sum, because of its monopoly position, Blue Cross enjoys enormous power on both sides of the equation: It has power over physicians who supply necessary services. And it has power over employers who purchase health benefits coverage for their employees. This case involves the use of that monopoly power, again on both sides of the equation, in order to maintain that monopoly and quash competition.

When Ocean State entered the Rhode Island market with its HMO, it offered a plan that provided significantly broader benefits at a lower cost than Blue Cross. It accomplished this, in part, through cost containment strategies, including vigorous utilization review and phy-

³ Merit C. Kimball, *Nation's Health Bill to Rise 10.4% in 1990, U.S. Says*, Healthweek, January 8, 1990, at p. 1, Col. 1.

sician incentives. In providing broader benefits at reduced cost, Ocean State threatened the entrenched traditional plan with active price and quality competition. In a relatively short time, Ocean State began to attract an increasing number of physicians to the plan—one important factor (in addition to lower price) in expanding the plan's appeal to employers.

Blue Cross thereupon devised a formalized plan of attack on Ocean State. That plan had three components, as follows:

A. "Prudent Buyer."

Blue Cross announced that it would no longer pay a physician the full Blue Cross rates if the physician accepted lower rates from Ocean State. In essence, Blue Cross offered to pay *more* to any physician if he or she ceased participating in Ocean State's competing plan. The natural, probable, and intended effect of this strategy was that physicians would defect from Ocean State: many physicians simply could not afford to accept less for their services from Blue Cross (which, as a monopolist, provided the dominant share of their patients), so they had to quit Ocean State. To avoid further defections, Ocean State had to raise its payments to physicians, thus increasing its costs.

The Court of Appeals ignored the obvious anticompetitive intent and effect of this tactic and decided that the policy could be sustained as an attempt by Blue Cross to *reduce* payments to physicians who were willing to accept lower payments. Noting a reluctance "to interfere in the domain of medical costs," *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1111 (1st Cir. 1989), the Court of Appeals held that a dominant firm, with power over physicians, can coerce those physicians not to deal with a new entrant, or not to offer economically sensible prices to the new entrant, so long as it does so by stating that it is imposing a lower price to match

that offered the new entrant. The Court's rule suggests that this is somehow different from the plainly pernicious practice of paying a physician bonuses if the physician agrees not to deal with the incipient competitor or agrees not to offer the competitor a lower price—even though the incipient competitor may need the lower price to survive. According to the Court of Appeals, it is of no matter that the purpose and effect of the tactic in both cases would be exclusionary.

The Court of Appeals' attempt to posit an efficiency justification and to use it to override the jury verdict that Blue Cross' conduct was an attempt to impose higher costs on a weaker competitor, flouts the tenets of economic efficiency and consumer welfare embodied in Section 2 of the Sherman Act. In the absence of the exclusionary plan, physicians would have remained free to charge lower prices to Ocean State (a practice that is clearly economically rational from the *physician's* perspective, in order to increase the physician's total earnings) and thereby increase consumer choice among competing plans. In the presence of Blue Cross' exclusionary plan, however, the reverse would occur: Blue Cross would effectively maintain its (high) prices to physicians who defected from Ocean State, and Ocean State's ability to offer a lowered price alternative would be undermined by having to choose between operating with fewer physicians (making its plan less attractive to consumers) or matching Blue Cross' higher rates.

Blue Cross could not have been unaware of the natural and probable effect of its approach—to cause physicians to quit Ocean State, or cause Ocean State to raise its prices. Such conduct is roughly analogous to an unlawful exclusive dealing arrangement or boycott where the monopoly buyer conditions the availability of high-priced purchases (desired by supplier-physicians) on the discontinued patronage of a competitor. It is not similar to cases dealing with price reductions to the ultimate con-

sumer, which the Court of Appeals seemed to have in mind when it raised lower price as a justification for sustaining the conduct. Here, the undisputed effect of Blue Cross' conduct was to exclude or weaken a low cost supplier of health care services. The exclusionary aspect of the plan was clear. The issue of the use of predatory purchasing power to maintain a monopoly in the health care field deserves the attention of the Court.

B. "HealthMate."

The second prong of Blue Cross' effort to thwart competition from Ocean State was to set up a look-alike HMO, a "fighting ship," which it marketed *only* to employers who also offered or were known to be considering the Ocean State plan, and only as an adjunct to an employer's purchase of the traditional Blue Cross plan. Blue Cross did not consider HealthMate to be financially viable in the long run, though it was effective in thwarting the growth of its competitor's business. HealthMate was marketed by offering discounts on the *traditional* Blue Cross plan (the monopoly plan that employers realistically could not refuse) *if* employers would offer HealthMate to their employees as a further alternative to Ocean State's HMO. Blue Cross offered even lower rates if those employers got rid of Ocean State altogether and ceased to offer it to their employees.

C. Adverse Selection.

Under Blue Cross' "Adverse Selection" policy, Blue Cross used the rates for its traditional plan—the one plan that employers could not be without—as a lever in connection with the employer's choice of HMO: "The rate was lowest for an employer who offered *only* traditional Blue Cross, intermediate for an employer who also offered a competing HMO (usually Ocean State) and HealthMate, and highest for an employer who also

offered a competing HMO but declined to offer Health-Mate." 883 F.2d at 1103 (emphasis in original).

The asserted justification for this tactic—that healthier employees in the groups might tend to favor HMOs, leaving Blue Cross with an unhealthier group of employees—is facially plausible, but was not supported by any actuarial estimate of the size of any adverse selection factor or any determination that the rates set were reasonable on that basis. Certainly this conduct could not be shown to be "no more restrictive than necessary"—the standard test for judging a monopolist's conduct that has an exclusionary effect. The explanation for the differential charge where HealthMate was not offered, and where HealthMate was offered by the employer in conjunction with Ocean State, was left unexplained. The reason why, if the rates were reasonably balanced, HealthMate was not offered along with Blue Cross unless the employer was considering Ocean State, was also not explained.

The natural, probable and intended effect of Blue Cross' tactic was clearly discernible: to exclude Ocean State. The use of discriminatory pricing by the powerful Blue Cross plan—the plan that employers effectively were required to carry—in order to lever those employers into offering HealthMate or abandoning Ocean State, is rendered further suspect by the limited marketing of HealthMate only to employers who were offering Ocean State. This was not an attempt to attract employers to Blue Cross products because of their competitive merits. It can only be seen, and was seen by the jury, as an attempt to force employers to forego their decision to offer a competing health plan, and thereby restrict the growth of a competitor. The court below conceded as much. 883 F.2d at 1104, n.4. And again, it could only be effective by virtue of the monopolist's market power.

Nonetheless, the Court of Appeals found that all issues relating to the decision to market HealthMate, the man-

ner of marketing HealthMate, and the rate differentials, were the "business of insurance," and thus exempt from the antitrust laws under the McCarran-Ferguson Act. The McCarran-Ferguson exemption is "inapplicable to any . . . act of boycott, coercion, or intimidation"; but the court rejected the contention that there was any coercion. The court found no coercion because Blue Cross did not leave the employers "no choice" in the matter; employers merely faced, in a plan that they could not realistically reject, rate increases that were "greater than they otherwise would have been." ⁴ *Id.* at 1109.

The court below turns a blind eye to the inherent power of a monopolist when the court suggests that the monopolist is not exercising coercion when it employs its monopoly power in the form of price differentials for the product of the monopolist—a product which employers, in a very real sense, are virtually compelled to purchase irrespective of price—puts significant economic pressure on those employers. Indeed, price differentials that penalize those who deal with one's competitors have long been recognized as "coercive" for purposes of the Sherman Act. *E.g., United States Navigation Co. v. Cunard S.S. Co.*, 284 U.S. 474, 479-80 (1932). Congress certainly had this Sherman Act meaning for the term "coercion" in mind when it enacted the McCarran-Ferguson Act and affirmatively made "coercive" insurance activity subject to the Sherman Act.

⁴ The Court of Appeals also expressed the view that Ocean State had waived the coercion argument by not raising it in its initial brief on appeal. This suggestion would not prevent review of that issue in this Court. The district court did not decide the case under McCarran-Ferguson, and there was thus no reason to discuss the inapplicability of McCarran-Ferguson in the opening brief. Moreover, it is plain that the Court of Appeals did, in fact, consider the issue on the merits, purporting to state a view with binding precedential effect. It did not rely on the supposed procedural default to preclude consideration of the issue in that court, and thus it is no bar in this Court.

To suggest that the monopolist is not employing coercion when it imposes a price penalty on those who deal with a potential competitor is simply to deny the meaning of monopoly power. Here we must assume that the adverse selection policy, although rational in basic conception, was not justifiable in fact—that is what the jury found. Similarly, the manner in which Blue Cross used access to its traditional plan to foist HealthMate on employers also involved a clear use of Blue Cross' monopoly power. The "coercion" exemption from McCarran-Ferguson is of vital significance in considering the actions of a monopolist "insurer", and is of vital importance, given the dominant role of the traditional plans in the health care field.

But even if the "insurance" aspects of Blue Cross' strategy were protected standing alone, this Court has made it clear that an anticompetitive plan is not to be judged "by dismembering it and viewing its separate parts, but only by looking at it as a whole." *United States v. Patten*, 226 U.S. 525, 544 (1913). See *Continental Ore Co. v. Union Carbide & Carbon Corp.*, 370 U.S. 690, 698-99 (1962). It is one thing to suggest that conduct that is subject to some statutory exemption cannot, in itself, be a violation of the antitrust laws. It is quite another thing to suggest that where there is an active plan to monopolize, including several elements, all otherwise unlawful, the jury cannot consider exempt conduct as part of an overall scheme of which it is, *in fact*, a part. Nothing in the language of McCarran-Ferguson suggests that result; the exemption itself is phrased primarily in the form of an intention not to preempt state law. Therefore, if the "prudent buyer" policy is unlawful, and HealthMate and Adverse Selection part and parcel of a single plan of which that was one part, it may be sufficient to hold in this case that McCarran-Ferguson cannot exempt Blue Cross' overall scheme from the reach of the antitrust laws.

CONCLUSION

The decision of the Court of Appeals simply ignores the power of the monopolist, and sanctions the abuse of monopoly power, power that is real and tangible to those that are its victims. Here, as plausibly found by a jury, monopoly power was used to quash potential competition and maintain a monopoly. Kaiser is concerned about the decision because it presents a blueprint for the maintenance of monopoly power that is readily applicable to other markets and involves an important segment of the health care industry. The issues presented are of importance to the promotion of competition in that industry and to a proper understanding of Section 2 of the Sherman Act. Therefore, the writ of certiorari should be issued by this Court to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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IN THE
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OCTOBER TERM, 1989

**OCEAN STATE PHYSICIANS HEALTH
PLAN, INC., ET AL.,**

Petitioners,

v.

**BLUE CROSS AND BLUE SHIELD
OF RHODE ISLAND,**

Respondent.

**On Petition For Writ Of Certiorari To The United
States Court Of Appeals For The First Circuit**

**BRIEF OF THE AMERICAN DENTAL ASSOCIATION
AS *AMICUS CURIAE*
IN SUPPORT OF PETITIONERS**

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TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	ii
STATEMENT OF INTEREST	1
SUMMARY OF ARGUMENT	4
ARGUMENT:	
A.	
THE CONDUCT OF BLUE CROSS WAS THE PREDATORY ACTIVITY OF A MONOPOLIST ..	4
B.	
THE McCARRAN-FERGUSON ACT DOES NOT SHIELD BLUE CROSS FROM ANTI- TRUST SCRUTINY AS TO ITS INTENTIONS ..	8
CONCLUSION	10

TABLE OF AUTHORITIES

<i>Cases</i>		
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)		8, 9
<i>Berkey Photo, Inc. v. Eastman Kodak Co.</i> , 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980)		7, 8, 9
<i>Catalano, Inc. v. Target Sales, Inc.</i> , 446 U.S. 643 (1980)		7
<i>F.T.C. v. Superior Court Trial Lawyers Ass'n</i> , U.S. ___, 110 S.Ct. 768 (1990)		5
<i>Goldfarb v. Virginia State Bar</i> , 421 U.S. 773 (1975) ..		5
<i>Group Life & Health Ins. Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979)		5, 8
<i>National Macaroni Manufacturers Ass'n v. F.T.C.</i> , 345 F.2d 421 (7th Cir. 1965)		7
<i>Ocean State Physicians Health Plan v. Blue Cross</i> , 883 F.2d 1101 (1st Cir. 1989)		4
<i>S.E.C. v. National Securities, Inc.</i> , 393 U.S. 453 (1969)		5
<i>Statutes</i>		
<i>McCarran-Ferguson Act</i>		
Section 2, 15 U.S.C. Section 1012		8
Section 3, 15 U.S.C. Section 1013		8
<i>Sherman Act</i>		
Section 2, 15 U.S.C. Section 2		4
<i>Other Authorities</i>		
<i>Bureau of Competition, F.T.C., Staff Report on Medical Participation and Control of Blue Shield and Certain Other Open-panel Medical Prepayment Plans, April 1979 (unpublished)</i>		5

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**BRIEF OF THE AMERICAN DENTAL ASSOCIATION AS
AMICUS CURIAE IN SUPPORT OF PETITIONERS**

The American Dental Association respectfully submits this brief *amicus curiae* in support of the petition for a writ of certiorari filed by petitioner. This brief *amicus curiae* is filed with the written consent of all parties.

INTEREST OF AMICUS CURIAE

The American Dental Association ("ADA") is organized as a not-for-profit corporation under the laws of the State of Illinois. It is a voluntary professional association with

over 140,000 practicing member dentists, representing approximately 75% of this nation's dentists. The stated object of ADA is to encourage the improvement of the oral health of the public and to promote the art and science of dentistry.

The facts in this case specifically involve reimbursement of physicians for professional services. The key issues, however, concern the method by which all independent health care professionals in the United States can compete with dominant health care financing entities with respect to the marketing and reimbursement of their services. As is the case in medicine, and reflected in the facts of this case, many markets for the financing of dental care are dominated by one or two insurance companies or service benefit corporations, such as respondent, Blue Cross. These third parties thus wield tremendous monopoly power. However, at the provider level, and probably to a greater extent than medicine, the overwhelming number of dental practices consist of sole practitioners or groups of two or three. Thus, horizontally, the practice of dentistry reflects the historic free market concept.

The independent practice association ("IPA") is a vertical integration by health care providers to create a product of their health services which can be marketed to the health care financing entities, either the dominant fee-for-service insurance companies, such as Blue Cross, or health maintenance organizations ("HMOs"), which appear to be the primary alternative financing system.

The antitrust enforcement agencies have issued stringent guidelines as to the structure and conduct of the IPA, because it represents a combination of competitors. Antitrust enforcement experts have suggested that such organizations should constitute less than 35% of the providers in a geographic market area, that the providers

should undertake significant risk sharing, and that other efficiencies should be evident from the integration, such as utilization control or peer review. "Health Care and Antitrust Enforcement: The Buyer's Eye View," remarks of Charles F. Rule, Assistant Attorney General, Antitrust Division (February 28, 1989); "Antitrust Enforcement and Health Care: Current Developments and Future Trends," remarks of Robert E. Bloch, Chief, Professions and Intellectual Property Section, Antitrust Division (November 4, 1989).

This close antitrust scrutiny of the IPA stands in stark contrast to the opinion of the Court of Appeals in this case with respect to permissible actions of a monopolistic health care financing entity. The appellate decision in effect establishes a *per se* rule of legality for any competitive reaction by a monopolist insurer if undertaken under the protection of a colorable business reason. If permitted to stand, this decision will hinder, or render impossible, emerging competition to the dominant insurance companies in the health care financing market, including dentistry. Such a development will filter down and foreclose opportunities for competition at the IPA level. ADA believes that this decision by the Court of Appeals was in error, and that if allowed to stand it will severely injure the competitive process in health care, including dentistry. It should be noted that ADA strenuously supports the traditional modes of third party reimbursement of providers that retain the concept of allowing patients to select the provider of their choice ("freedom of choice"). It is ironic, therefore, for ADA to support in this case the position of an alternative mode of health care delivery. The key issue which has compelled ADA to speak out in this instance is the apparent unfettered right of a traditional third party financing entity to engage in anticompetitive monopolistic behavior.

An effort has been made in the preparation of this brief *amicus curiae* to avoid a mere repetition of the arguments made by the petitioner and the other *amici curiae* in support of the petition. ADA is in substantial agreement with the arguments made in the brief *amicus curiae* filed by the American Medical Association.

SUMMARY OF ARGUMENT

Blue Cross should not be protected from the intended consequences of its actions in this case by the insurance exemption to the antitrust laws. The jury's verdict pronounced these actions to be the predatory activity of a monopolist. As such, they fall outside of the insurance exemption and, under existing and well reasoned precedent, constitute a violation of Section 2 of the Sherman Act.

ARGUMENT

A.

THE CONDUCT OF BLUE CROSS WAS THE PREDATORY ACTIVITY OF A MONOPOLIST.

Blue Cross has conceded that it has monopoly power in the health care insurance market in Rhode Island. Ocean State has acknowledged that Blue Cross has acquired these historical advantages legitimately. *Ocean State Physicians Health Plan v. Blue Cross*, 883 F.2d 1101, 1110 (1st Cir. 1989). Whatever the historic reasons for the current monopoly position, it can be safely assumed that this

market advantage was not forged in the heat of competition. Nearly all Blues plans, as is the case with service benefit dental health insurance, were initiated by providers and substantially controlled by them to the point where they obtained their dominant market position.¹ While these dominant plans are no longer subject to provider control, they remain non-profit entities with limited incentive, other than competition, to introduce efficiencies with respect to their products or services.

The fact that these third parties were allowed to achieve such dominance in provider reimbursement while under the control of providers is something of an anomaly that can be explained only by a combination of two historical accidents. First, such power arose before this Court defined and narrowed the insurance exemption to the antitrust laws. *S.E.C. v. National Securities, Inc.*, 393 U.S. 453 (1969); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Second, this market dominance developed before this Court's decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975) and its progeny, through the recent decision in *F.T.C. v. Superior Court Trial Lawyers Ass'n*, ____ U.S. ___, 110 S. Ct. 768 (1990), generally applying the antitrust laws to the professions. In sum, there is no showing that Blue Cross's monopoly position in this case resulted from a superior product, business acumen or other economic efficiencies.

In this context, the antitrust laws should not favor the support or protection of monopoly status of an entity which achieved its dominant position in substantial part because

¹ See *Bureau of Competition, FTC, Staff Report on Medical Participation and Control of Blue Shield and Certain Other Open-panel Medical Prepayment Plans*, April 1979 (unpublished).

it was not subject to the scrutiny of the antitrust laws. This argument is especially compelling absent any showing of market efficiencies resulting from the conduct of the monopolist.

Viewing the evidence most favorably to the petitioner, the actions of Blue Cross were:

- The establishment of HealthMate, an HMO look-alike to compete with Ocean State. It had no expectation that HealthMate would be profitable. Its main purpose was to slow or stop Ocean State's growth and seek to make Ocean State unprofitable.
- The establishment of a pricing differential on its principal product, fee-for-service health care financing coverage. This coverage was available at the lowest rate from Blue Cross if the purchaser took neither the Blue Cross HMO look-alike nor Ocean State. The cost increased if the purchaser took HealthMate. It increased further if Ocean State or another competitor's HMO were also offered.
- The introduction of a "Prudent Buyer" or "most favored nations" concept into its reimbursement of physicians, i.e., if a physician accepted a lower fee from Ocean State than that ordinarily paid by Blue Cross, Blue Cross also required the physician to take the lower fee from it rather than its ordinary payment.

Petitioner asserts that the evidentiary record shows the "Prudent Buyer" plan was imposed only against the physicians working for Ocean State. Petitioner further asserts that Blue Cross actually encouraged physicians to drop from Ocean State, thus raising Blue Cross's own costs, which amply demonstrates that the motivating purpose of this activity was not to economize but to punish Ocean State. Petitioner's Brief, at p. 21.

This activity certainly is of the type that the antitrust laws would address if carried out in combination by two independent entities, albeit with a total market share much less than that enjoyed by Blue Cross. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *National Macaroni Manufacturers Ass'n v. F.T.C.*, 345 F.2d 421 (7th Cir. 1965). Similarly, a monopolist, who has obtained monopoly power because of an exemption from the antitrust laws, should not be permitted to engage in such activity absent a showing of market efficiency.

The court in *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093 (1980) ("*Berkey Photo*") found the dominant market entity's conduct justified on the basis of the efficiencies inherent in innovative new products. Blue Cross's actions in seeking to raise costs to its rival Ocean State, sometimes at increased costs or loss of market share to Blue Cross, are not justified under the reasoning in *Berkey Photo*. To the contrary, if the ruling by the Court of Appeals is left undisturbed, the costs to the consumer will rise. Most medical and dental health plans which reimburse the provider on the basis of a usual and reasonable fee do not prohibit balance billing. Therefore, were the "most favored nations" pricing policy of Blue Cross in this case to become widespread, some of the amounts not reimbursed under such a pricing policy inevitably would be passed to the consumer in order to make up the difference between the lower amount reimbursed by the insurance company and the fee of the provider. The opinion of the Court of Appeals did not consider that consumers in an HMO achieve purported lower costs by giving up some things in return, such as an unlimited or free selection of the treating doctor. Blue Cross sought to impose its fee reductions (with the possibility of higher cost to the

non-HMO patient) on providers treating patients who were not willing to make this trade-off. In the words of *Berkey Photo*, this is conduct ". . . which a firm would have found substantially less effective, or even counterproductive, if it lacked market control." 603 F.2d at 291.

B.

THE McCARRAN-FERGUSON ACT DOES NOT SHIELD BLUE CROSS FROM ANTITRUST SCRUTINY AS TO ITS INTENTIONS.

Blue Cross should not be afforded immunity for its predatory actions under the McCarran-Ferguson Act, 15 U.S.C. Sections 1012(b), 1013(b) ("Act"). The Court of Appeals' application of this statute was in error for two reasons.

First, it was inappropriate to segregate Blue Cross's conduct with regard to the commencement, marketing and pricing of its HMO look-alike and consider these activities solely in the context of whether they constituted the business of insurance. Intention is a consideration in the analysis of whether a monopolist's activity constitutes prohibited predatory conduct. *Aspen Skiing Co. v. Aspen Highland Skiing Corp.*, 472 U.S. 585, 605 (1985) ("Aspen Skiing"). Thus, if the totality of Blue Cross's actions indicate an intention to exclude a competitor by methods not permitted to a monopolist, the fact that some of the activity arguably falls within the Act's exemption is of no import.

Second, in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 221-22 (1979), this Court ruled that the primary purpose of the insurance exemption is to permit separate entities to share information on such subjects as rate setting and statistical matters to carry on the business of insurance more efficiently under the auspices of

state regulation. It cannot seriously be argued that Congress intended, or that the language of the Act provides, that the activities of a monopolist, designed primarily to intimidate and frustrate an emerging rival, rather than to bring efficiencies to the marketplace or the consumer, are protected under this Act.

The jury verdict in this case must be interpreted as a determination that Blue Cross's activity was primarily predatory. This predatory conduct should be more than sufficient to fall within the definition that, "(i)f a firm has been 'attempting to exclude rivals on some basis other than efficiency,' it is fair to characterize its behavior as predatory." *Aspen Skiing*, 472 U.S. at 605 (footnote omitted).

The Court of Appeals in this case has established a *per se* rule of legality for any self-interested conduct of a monopolist with a colorable business purpose. Such approval will not result in furthering constructive competition. What is required in this case is an economic analysis of the monopolist's activity, similar to a rule of reason approach. *Aspen Skiing Co. v. Aspen Highland Skiing Corp.*, 472 U.S. 585 (1985), *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980).

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CONCLUSION

For all the foregoing reasons, the petition for certiorari should be granted.

Respectfully submitted,

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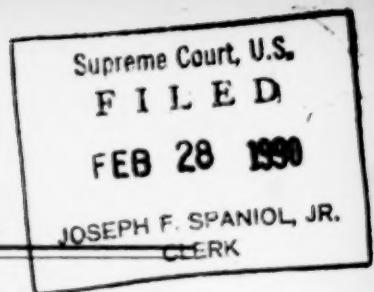
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February 28, 1990



No. 89-1044



IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH
PLAN, INC., ET AL.,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD
OF RHODE ISLAND,

Respondent.

On Petition For Writ Of Certiorari To The United
States Court Of Appeals For The First Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION
AS *AMICUS CURIAE* IN SUPPORT OF OCEAN
STATE PHYSICIANS HEALTH PLAN, INC., ET AL.

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228



TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	ii
INTEREST OF AMICUS	2
INTRODUCTION	3
REASON FOR GRANTING THE WRIT	7
SUMMARY OF ARGUMENT	8
 ARGUMENT:	
THE COURT OF APPEALS WRONGLY HELD THAT MOST FAVORED NATIONS CLAUSES AT ABOVE-COST PRICES CANNOT BE EXCLUSIONARY	9
A. The Blue Cross Most Favored Nations Clause Was A Type Of Nonprice Preda- tion, Not Predatory Pricing	9
B. The Blue Cross Most Favored Nations Clause Was Exclusionary	12
C. The Blue Cross Most Favored Nations Clause Was Not A Legitimate Cost Sav- ing Device	14
CONCLUSION	17

TABLE OF AUTHORITIES

Cases	PAGE	
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	10	
<i>Barry Wright Corp. v. ITT Grinnell Corp.</i> , 724 F.2d 227 (1st Cir. 1983)	10	
<i>Berkey Photo, Inc. v. Eastman Kodak Co.</i> , 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980)	17	
<i>Kartell v. Blue Shield of Massachusetts</i> , 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985)	11	
<i>Matsushita Electric Industrial Co. v. Zenith Radio Corp.</i> , 475 U.S. 574 (1986)	10	
<i>Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island</i> , 883 F.2d 1101 (1st Cir. 1989)	<i>passim</i>	
<i>Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island</i> , 692 F. Supp. 52 (D.R.I. 1988)	<i>passim</i>	
<i>Reazin v. Blue Cross & Blue Shield of Kansas</i> , 663 F. Supp. 1360 (D.Kan. 1987)	13, 14	
<i>United Mine Workers v. Pennington</i> , 381 U.S. 657 (1965)	14	
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563 (1966)	9	
<i>Other Authorities</i>		
<i>American Medical Association, How to Evaluate a Managed Care System Contract</i> (1988)	3	
<i>P. Areeda & D. Turner, Antitrust Law</i> (1978) ...	10	

Baker, <i>Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rivals' Costs</i> , 14 Am. J. Law & Med. 147 (1988) ..	8, 15, 16
Belkin, <i>Many in Medicine are Calling Rules a Professional Malaise</i> , N.Y. Times, Feb. 19, 1990, at A1	4
Campbell, <i>Predation and Competition in Antitrust: The Case of Nonfungible Goods</i> , 87 Colum. L. Rev. 1625 (1987)	10, 11, 14
Clark, <i>Price-Fixing Without Collusion: An Antitrust Analysis of Facilitating Practices After Ethyl Corp.</i> , 1983 Wisc. Law Rev. 887	11, 12
Easterbrook, <i>Predatory Strategies and Counter-strategies</i> , 48 U. Chi. L. Rev. 263 (1981)	10
Hovenkamp, <i>Vertical Restrictions and Monopoly Power</i> , 64 Boston Univ. L. Rev. 521 (1984) ..	12
Krattenmaker & Salop, <i>Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price</i> , 96 Yale L.J. 209 (1986)	8, 10
Miller, <i>Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading As Managed Care?</i> , 51 Law & Contemporary Problems 195 (1988)	8, 13, 15
Pauly, <i>Competition in Health Insurance Markets</i> , 51 Law & Contemporary Problems 237 (1988) ..	7
C. F. Rule, Assistant Attorney General, Antitrust Division, Remarks Before the Connecticut Bar Association, <i>Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation</i> (March 11, 1988)	12, 15
C. F. Rule, Assistant Attorney General, Antitrust Division, Remarks Before the Group Health Association of America, <i>Health Care and Antitrust Enforcement: The Buyer's Eye-View</i> (Feb. 28, 1989)	3, 4
United States Department of Commerce, <i>Statistical Abstract of the United States</i> (1989)	4



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Respondent.

**On Petition For Writ Of Certiorari To The United
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**BRIEF OF THE AMERICAN MEDICAL ASSOCIATION
AS *AMICUS CURIAE* IN SUPPORT OF OCEAN
STATE PHYSICIANS HEALTH PLAN, INC., ET AL.**

The American Medical Association respectfully submits this brief as *amicus curiae* in support of Ocean State Physicians Health Plan, et al. The written consent of all parties has been obtained and filed with the Clerk in accordance with Supreme Court Rule 36.2.

INTEREST OF AMICUS CURIAE

The American Medical Association ("AMA") is a private, voluntary nonprofit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and the improvement of the public health. Its membership exceeds 285,000 physicians and medical students.

The AMA is dedicated to promoting the public welfare through the maintenance of appropriate professional standards and the provision of quality health care. The AMA believes that a competitive market for physician services is essential to this goal by assuring the efficient delivery of the health care needed by the public. Preservation of competition in the marketplace depends upon fair and equitable enforcement of the antitrust laws.

The Court of Appeals decision in this case has nationwide ramifications with respect to the ability of dominant medical insurers to use their market power to disrupt competition in the market for physician services. Respondent in this proceeding, Blue Cross and Blue Shield of Rhode Island ("Blue Cross"), has conceded that it possesses market power, and it is the position of the AMA that respondent has abused that market power through the practices at issue in this case. The AMA participates in this proceeding to urge the Court to grant the petition for certiorari and to protect the emerging competition of small health insurers from the improper exercise of market power.

INTRODUCTION

Petitioner Ocean State Physicians Health Plan ("Ocean State") is a primarily physician-sponsored Health Maintenance Organization ("HMO") which has operated in Rhode Island since 1984. *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, 883 F.2d 1101, 1103 (1st Cir. 1989).¹ An HMO is an organized system of health care delivery which provides comprehensive health services to voluntarily enrolled members. HMOs combine both delivery and financing of health care in one system. Members do not submit claims for reimbursement, as in an indemnity insurance plan, but rather pay a fixed monthly fee regardless of the services received. American Medical Association, *How to Evaluate a Managed Care System Contract* p. 67 (1988).

HMOs have several characteristics which enable them to operate at a lower cost than traditional indemnity insurers. Among these are (1) the provision of better information to consumers regarding health care services; (2) the use of utilization review, patient copayments, and physician incentives to reduce the incidence of unnecessary services; and (3) the integration of various components of health care delivery (e.g., general practitioners, specialists, and hospitals) to create efficiencies. C. F. Rule, Assistant Attorney General, Antitrust Division, Remarks Before the Group Health Association of America, *Health Care and Antitrust Enforcement: The Buyer's Eye-View*, p.4-5 (Feb. 28, 1989).

¹ The opinion of the district court in this case is reported at 692 F.Supp. 52. The decisions of both courts below are reprinted in the Petitioners' Appendix.

The efficiency of HMOs has enabled them to compete successfully with other health care insurers, especially indemnity plans such as Blue Cross. HMOs grew from 175 plans with 6 million members in 1976 to 662 plans with 28.5 million members in 1987. United States Department of Commerce, *Statistical Abstract of the United States* p.97 (1989). By January, 1990, there were 607 HMOs serving 32.5 million people—nearly 13 percent of the population. Belkin, *Many in Medicine are Calling Rules a Professional Malaise*, N. Y. Times, Feb. 19, 1990, at A1.

The Department of Justice understands the importance of the antitrust laws in preserving competition by HMOs. "The antitrust laws serve to ensure that these nascent market forces are allowed to continue to develop and that American consumers of health care are able to enjoy the economic benefits of those developments." Remarks of C. F. Rule, *Health Care and Antitrust Enforcement* at 6.

This case is an example of the use of market power by a large indemnity insurer to squelch the successful entry of an efficient HMO. Respondent Blue Cross is by far the largest health insurer in Rhode Island. The district court found that Blue Cross "clearly had market power." 692 F.Supp. at 58. On appeal, Blue Cross conceded that it possesses monopoly power in the health insurance market. 883 F.2d at 1110. Blue Cross is also the dominant purchaser or marketer of physician services in Rhode Island. Ninety percent of the state's physicians participate in Blue Cross plans. (J.A. 52, 318-20.)²

² References are to the Joint Appendix ("J.A.") and Plaintiff's Exhibits ("P.E.") in the record on appeal.

Ocean State and Blue Cross compete directly by offering their health benefit plans to employers. Prior to Ocean State's entry to the market, "competition from other health care financing insurers was virtually non-existent." 692 F.Supp. at 56. Although Blue Cross is much larger, Ocean State has proven to be a successful competitor. It exceeded all expectations and grew to 70,000 subscribers by the Spring of 1986. 692 F. Supp. at 57. During the same period, Blue Cross lost 30,000 subscribers. *Id.*

Ocean State was successful due to its 1,200 participating physicians, as well as its use of several cost-saving programs, including utilization review and physician incentives. (J.A. 763, 806-07, 2167-69; P.E. 45.) Moreover, Ocean State's physicians shared in the risk of loss of the venture. Twenty percent of their fees were withheld contingent on Ocean State's profitability, enabling it to offer a health benefit package 15 percent broader than the Blue Cross plan at a 5-7 percent lower price. (P.E. 45.) Ocean State returned the withhold to physicians in 1984, but retained it in 1985 due to higher than anticipated operating expenses. 692 F.Supp. at 60.

Following the entry of Ocean State and the subsequent loss of 30,000 subscribers, Blue Cross raised its premium rates to maintain sufficient cash reserves to meet state law requirements. These price increases led to further enrollment losses and additional premium increases. 692 F.Supp. at 57. As a result, Blue Cross lost over \$26 million on its group insurance business, and a substantial number of subscribers as well, during an 18-month period in 1985 and 1986. (J.A. 1109-10; 2017.) Blue Cross then launched a three-pronged plan directed at Ocean State. 692 F.Supp. at 58. The initiative included a new pricing policy which discriminated against employers who offered

a competing health plan (adverse selection), the introduction of an HMO (HealthMate), and the use of a most favored nations clause, called Prudent Buyer.³ This brief focuses only on the legality of the Prudent Buyer policy.

The Prudent Buyer policy provided that Blue Cross would not pay more for physician's services than any of its competitors. 692 F.Supp. at 60. Blue Cross implemented this most favored nations policy by reducing fees of Ocean State physicians by 20 percent. *Id.* at 60-61. This amount reflected the withhold Ocean State physicians accepted as a risk sharing and cost containment device. *Id.* The Blue Cross fee reduction was a pure discount, and did not reflect risk sharing or any cost containment incentive. Moreover, this most favored nations policy was followed primarily with respect to Ocean State physicians, and not with Blue Cross' other competitors. (J.A. 780.)

The effect of Blue Cross' strategy was quick and decisive. Ocean State lost nearly one-third of its physicians, incurred a substantial increase in costs, and lost subscribers. 692 F.Supp. at 61. Ocean State's costs increased because the loss of 350 participating physicians forced it to secure services from non-participating physicians at a higher price. Non-participating physicians are those who had not agreed to the twenty percent withhold of their fees. Blue Cross, meanwhile, was able to implement a prompt increase in premiums and realize a \$10 million surplus. (J.A. 1110-13, 1847-49, 2183-84.)

³ The Court of Appeals held that the implementation of the adverse selection policy and HealthMate were exempt from the anti-trust laws under the McCarran-Ferguson Act. 883 F.2d at 1109. That issue will not be addressed in this brief.

REASON FOR GRANTING THE WRIT

There is an important reason for granting the petition for a writ of certiorari in this case. The decision below condoned exclusionary conduct by a monopolist which injured an efficient new competitor. Blue Cross imposed a most favored nations clause on physicians which was designed to, and did, cause many of them to resign from Ocean State. Having thus raised its rival's costs, Blue Cross was able to increase its prices and harm not only Ocean State but also the public.

If permitted to stand, the decision below could result in similar injury to fledgling HMOs throughout the country. In ruling that the Blue Cross Prudent Buyer policy was lawful because it did not force physicians' prices below cost, the Court of Appeals foreclosed any meaningful opportunity to protect smaller competitors from efforts by dominant rivals to drive them from the market through the use of most favored nations clauses. Significantly, respondent Blue Cross is not the only dominant health insurer in this country. Blue Cross plans in several states have substantial market shares, particularly in relation to their competitors. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemporary Problems 237, 242-43 (1988). The use of most favored nations clauses or similar predatory tactics by these large insurers would harm the public by significantly limiting the ability of managed care plans to compete.

SUMMARY OF ARGUMENT

The Court of Appeals erroneously held that a "most favored nations" policy implemented by a monopolist is not exclusionary (and therefore not unlawful) unless the supplier is forced to sell below its cost. 883 F.2d at 1110. In so ruling, the court confused predatory pricing and nonprice predation. The issue whether price is below cost is relevant in a predatory pricing case because price is the means by which competition can be harmed. In a nonprice predation case, it is conduct *other* than price which may be exclusionary. For example, a most favored nations clause, particularly when imposed by a monopolist, can harm competitors because it *deters* discounting by suppliers. This can raise the costs of small firms and increase barriers to entry. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading As Managed Care?*, 51 Law & Contemporary Problems 195, 233 (1988); Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers that Raise Rivals' Costs*, 14 Am. J. Law & Med. 147, 168 (1988).

A firm such as Blue Cross which possesses market power can engage in predation against its rivals, not by pricing below cost, but by *increasing* the costs of its competitors. Krattenmaker & Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 Yale L.J. 209 (1986). The Court of Appeals ignored this element of exclusionary behavior in ruling that a most favored nations clause implemented by a monopolist is lawful unless suppliers are forced to sell below cost. Antitrust jurisprudence holds that a most favored nations clause can unreasonably harm competitors, regardless of the price suppliers charge.

ARGUMENT

THE COURT OF APPEALS WRONGLY HELD THAT MOST FAVORED NATIONS CLAUSES AT ABOVE-COST PRICES CANNOT BE EXCLUSIONARY.

The Prudent Buyer policy implemented by Blue Cross was the equivalent of requiring a most favored nations clause in the participation contracts of all physicians. The Court of Appeals viewed this practice as merely an attempt by Blue Cross to get the best price possible. But the record in this case, which is consistent with economic theory, shows that the purpose and effect of the Blue Cross policy was precisely the opposite: the most favored nations clause discouraged discounting by physicians and instead raised the costs of Blue Cross' rivals, especially Ocean State. This practice by Blue Cross was an abuse of market power and violated the Sherman Act.

A. The Blue Cross Most Favored Nations Clause Was A Type Of Nonprice Predation, Not Predatory Pricing.

The petitioners contend that the Blue Cross Prudent Buyer policy violated Section 2 of the Sherman Act, under which it is unlawful to "monopolize . . . any part of the trade or commerce among the several states." 15 U.S.C. §2. A plaintiff must prove two elements to establish the offense of monopolization: (1) the possession of monopoly power and (2) the willful acquisition or maintenance of that power. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). It has been shown that Blue Cross possesses monopoly power. The sole issue is whether Blue Cross improperly maintained that power.

Put another way, the issue is whether the Prudent Buyer policy constitutes "exclusionary" conduct, which is defined as "behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." 3 P. Areeda & D. Turner, *Antitrust Law* ¶626b at 78 (1978), quoted by *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985).

The courts have identified several types of behavior which are considered to be exclusionary. For example, predatory pricing, or pricing below cost, is unlawful conduct for a monopolist. *See, e.g., Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227, 232-33 (1st Cir. 1983). Many commentators have noted that predatory pricing is unlikely to occur, as the predator would suffer losses greater than those of the victim during the period of below-cost pricing. Moreover, the monopolist would draw new entrants when prices were increased to supra-competitive levels to recoup the lost profits. Easterbrook, *Predatory Strategies and Counterstrategies*, 48 U. Chi. L. Rev. 263, 272 (1981). This Court apparently agrees. *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 589-90 (1986) ("For this reason, there is a consensus among commentators that predatory pricing schemes are rarely tried, and even more rarely successful.")

There is a viable manner in which monopolists can engage in predation against their rivals, however. By raising their rivals' costs but not their own, monopolists can exclude competitors without suffering losses. The manner in which this can be done is to contract with suppliers for their agreement not to deal with the monopolist's competitors, or at least not to deal with them on equal terms. Krattenmaker & Salop, *Anticompetitive Exclusion*, 96 Yale L.J. at 223-24; Campbell, *Predation and Competition*

in Antitrust: The Case of Nonfungible Goods, 87 Colum. L. Rev. 1625, 1629 (1987).

A most favored nations clause, such as the Blue Cross Prudent Buyer policy, can be a means of raising rivals' costs. Generally, a most favored nations clause provides that the seller will pass on to the buyer any lower price offered to another buyer during the term of the contract. Clark, *Price-Fixing Without Collusion: An Antitrust Analysis of Facilitating Practices After Ethyl Corp.*, 1983 Wisc. L. Rev. 887, 901. Blue Cross imposed a most favored nations clause on Rhode Island physicians by insisting that it would pay no more for any service or procedure than any other payer. 883 F.2d at 1110.

The Court of Appeals below erroneously analyzed the Prudent Buyer policy as a predatory pricing case. In ruling that the Blue Cross most favored nations policy was not exclusionary as a matter of law because it did not cause physicians to sell their services at a price below cost, 883 F.2d at 1110, the court missed the point of a most favored nations clause entirely. The Prudent Buyer policy is illegal because it encouraged physicians *not to participate* in the plans of Ocean State and other Blue Cross competitors.⁴

⁴ The Court of Appeals' reliance on the *Kartell* case is likewise misplaced. 883 F.2d at 1110-11. *Kartell* involved an action by physicians against Blue Shield of Massachusetts challenging a policy which limited the amount physicians could bill patients. *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985). Petitioners in this case do not suggest that the law prohibits negotiation regarding fee levels between Blue Cross and physicians. As a monopolist, Blue Cross simply may not enter into contracts which unreasonably discourage physicians from dealing with managed care plans such as Ocean State.

B. The Blue Cross Most Favored Nations Clause Was Exclusionary.

While most favored nations clauses may appear to be a means of assuring lower prices, they usually have the opposite effect when imposed by a purchaser with market power. That is, most favored nations clauses *discourage* discounting by reducing sellers' incentives to decrease prices. With most favored nations clauses in effect, a seller contemplating a discount to one buyer knows that the discount must be given to *all* buyers with such a clause in their contracts. Any price decrease therefore becomes more expensive for the seller, and less likely to occur. Clark, *Price-Fixing Without Collusion*, 1983 Wisc. L. Rev. at 901-02, 932; Hovenkamp, *Vertical Restrictions and Monopoly Power*, 64 Boston Univ. L. Rev. 521, 539 n.92 (1984).

The United States Department of Justice has affirmed that the use of most favored nations clauses can harm competition in the health care market: (1) where the buyer imposing the clause is so significant that "a very high percentage of all providers feel they must contract with it," and (2) where the payer accounts for such a large portion of the providers' total billings that there would be an insufficient volume of provider services to support entry to the market by other payers. C. F. Rule, Assistant Attorney General, Antitrust Division, Remarks Before the Connecticut Bar Association, *Antitrust in the Health Care Field: Distinguishing Resistance From Adaptation* p.21-23 (March 11, 1988).

Both conditions exist in the present case. First, ninety percent of Rhode Island physicians contract with Blue Cross, no doubt due to their application of simple arithmetic—Blue Cross has over 500,000 subscribers, and the next largest private insurer has only 70,000. Second, Blue Cross accounts for such a large proportion of the business

of Rhode Island physicians that there are insufficient non-Blue Cross physicians to support a new entrant to compete with Blue Cross. After all, nearly one-third of Ocean State physicians found it more advantageous to forego participation with Ocean State entirely than to discount their Blue Cross business. Miller, *Vertical Restraints and Powerful Health Insurers*, 51 Law & Contemporary Problems at 233-34. Thus, the use of a most favored nations clause by Blue Cross alone was sufficient to discourage discounting by a substantial number of Ocean State physicians.

The holding of the Court of Appeals conflicts squarely with a recent district court opinion currently on appeal to the Court of Appeals for the Tenth Circuit. In that case, *Reazin v. Blue Cross & Blue Shield of Kansas*, 663 F.Supp. 1360 (D.Kan. 1987), Kansas Blue Shield implemented a most favored nations clause in its contracts with providers. 663 F.Supp. at 1375-76. Disgruntled providers and a competing HMO challenged this and other practices of Kansas Blue Shield. In ruling on post-trial motions following a jury verdict for the plaintiffs, the court commented on the effect of the most favored nations clause:

The jury could readily understand the existence of this clause effectively prevented discounting to other insurers, and . . . the "most favored nations" clause effectively prevents competing insurance companies from offering more favorable insurance rates to consumers. This clause gives defendant the ability to prevent insurance prices from falling, thus providing it the ability to effectively control insurance prices.

Reazin, 663 F.Supp. at 1418. Thus, the court recognized that rather than leading to *lower* prices, a most favored nations clause instituted by a dominant buyer can reduce discounting, and harm smaller, lower-priced competitors such as HMOs, resulting in higher prices for consumers.

This is particularly troubling in a market dominated by a large insurer because, as the *Reazin* court noted, HMOs and other alternative delivery systems represent the *only* effective challenge to the dominance of Blue Cross plans. 663 F.Supp. at 1417. The Blue Cross Prudent Buyer policy had precisely the same effects as the most favored nations clause in *Reazin*—it raised Ocean State's costs and enabled Blue Cross to increase the price of its premiums—and was likewise illegal.

In an analogous case, *United Mine Workers v. Pennington*, 381 U.S. 657 (1965), this court held that an industry-wide collective bargaining agreement whereby employers and a labor union agreed on a wage scale that exceeded the financial ability of some operators to pay, made for the purpose of forcing some employers out of business, was illegal. The labor agreement was simply a means of raising rivals' costs to exclude small competitors from the market, much like the most favored nations clause in the present case. See Campbell, *Predation and Competition in Antitrust*, 87 Colum. L. Rev. at 1629.

C. The Blue Cross Most Favored Nations Clause Was Not A Legitimate Cost Saving Device.

The Court of Appeals validated the Prudent Buyer policy because it was viewed simply as an attempt to achieve lower costs. 883 F.2d at 1110. But the discount imposed on physicians by Blue Cross was very different from the fee withhold agreed to by Ocean State physicians. Blue Cross forced a simple decrease in the amount physicians charged their patients. In contrast, physicians who contracted with Ocean State agreed to a twenty percent withhold as a means of sharing in the risk of Ocean State's profitability. These physicians did *not* discount the fees

charged their patients, but rather "allowed their reimbursement to vary with the financial health of the HMO." Baker, *Vertical Restraints*, 14 Am. J. Law & Med. at 161 n.55. Blue Cross physicians were assessed the fee reduction regardless of the profitability of Blue Cross.

Moreover, Ocean State, as an HMO, purchased a different commodity from physicians than did Blue Cross. Ocean State received a commitment to share the risk of the venture, and to engage in utilization review and other efficiency-enhancing programs. Blue Cross simply contracted for an agreement that physicians would not accept a lesser amount for their services from other insurers. See Remarks of C. F. Rule, *Antitrust in the Health Care Field* at 21-22. Blue Cross was therefore not attempting to assure that it paid no more than Ocean State for the *same* services; Blue Cross bargained for a different bundle of services.

The Court of Appeals also gave insufficient weight to evidence that the most favored nations policy was aimed at *raising* Ocean State's costs rather than lowering those of Blue Cross. Blue Cross applied the Prudent Buyer policy only to Ocean State physicians, and made no effort to determine whether other insurers received discounts from physicians. (J.A. 779-80, 845-46.) If Blue Cross were intent on lowering costs, why would it not apply the policy to all physicians? This incongruity has been found by commentators to be especially probative in noting the absence of a cost saving motive by Blue Cross. Baker, *Vertical Restraints*, 14 Am. J. Law & Med. at 161; Miller, *Vertical Restraints and Health Insurers*, 51 Law & Contemporary Problems at 234.

There is also direct evidence that Prudent Buyer was not intended as a cost saving device. Blue Cross made no estimates of anticipated cost savings in planning the Pru-

dent Buyer policy. (J.A. 336-37, 850-51.) Moreover, a Blue Cross executive testified that the Prudent Buyer program was not designed to lower Blue Cross' costs. 692 F.Supp. at 71. Finally, Blue Cross recognized the effect its most favored nations clause would have on Ocean State: "not one guy in the state isn't going to know the implication of signing with Ocean State." 883 F.2d at 1113.⁵

The Court of Appeals perceived the clarity of this intent evidence, but nevertheless held that intent to harm alone does not violate the Sherman Act. However, intent to harm by a monopolist together with conduct which substantially and unreasonably impedes the ability of competitors to contract with their suppliers *does* violate the law. By enacting the Prudent Buyer policy, Blue Cross has entrenched itself as the dominant insurer in Rhode Island. The most favored nations clause decreases the likelihood that physicians will discount their services to new HMOs, thereby increasing the costs of entry to the market. Baker, *Vertical Restraints*, 14 Am. J. Law & Med. at 168 n.78.

Finally, the Court of Appeals repeatedly remarked that Blue Cross was able to lower its costs to some degree by means of the Prudent Buyer policy, thereby creating "efficiencies." In fact, the court indicated that the creation of efficiencies alone is enough to find monopolistic conduct lawful.⁶ This is simply wrong. Conduct which has

⁵ The Court of Appeals termed this a *hope* on the part of Blue Cross that its actions would damage Ocean State. This curious choice of language for strongly-worded evidence of intent indicates the degree of deference granted Blue Cross by the court below.

⁶ "The fact remains that achieving lower costs is a legitimate business justification under the antitrust laws." 883 F.2d at 1111 n.11.

the purpose and effect of injuring rivals, increasing barriers to entry and enabling a monopolist to raise its prices cannot be condoned simply because the perpetrator's costs may decrease in the process. *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 273-74, 276 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980). There are certain things a monopolist may not do. Forcing a contract provision on suppliers which eliminates their financial incentive to deal with the monopolist's competitors is one of them.

CONCLUSION

For all the foregoing reasons, and for those set forth in the petition for certiorari, the petition for certiorari should be granted.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the First Circuit

BRIEF OF
GROUP HEALTH ASSOCIATION OF AMERICA, INC.
AS AMICUS CURIAE
IN SUPPORT OF THE PETITIONERS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICUS CURIAE	1
REASONS FOR GRANTING THE WRIT	5
I. INTRODUCTION	5
II. THE COURT BELOW GAVE IMPROPER CONCLUSIVE EFFECT TO THE EXISTENCE OF COST SAVINGS FOR BLUE CROSS	6
A. The Court of Appeals Misapprehended or Grossly Misapplied the Proper Standard For Assessing Whether Blue Cross's Prudent Buyer Policy Was Exclusionary by Failing to Consider Whether the Policy Was Unnecessarily Restrictive of Competition	8
B. The Court of Appeals Misapprehended the Role of Intent Evidence in Determining Whether Blue Cross's Conduct Was Exclusionary	10
C. The Prudent Buyer Policy Was Not a Means to Achieve the Same Low Price Charged to a Competitor	11
D. The Court of Appeals Erred in Declaring That the Prudent Buyer Policy Could Not Be Exclusionary if Blue Cross's Payments to Physicians Were Not "Predatory" or "Below Cost"	13
E. The Prudent Buyer Policy Was Unnecessarily Restrictive of Competition	14
III. THE COURT OF APPEALS TOO NARROWLY CONSTRUED THE EXCEPTION FROM ANTITRUST IMMUNITY UNDER THE McCARRAN-FERGUSON ACT FOR ACTS OF COERCION	16
CONCLUSION	19

TABLE OF AUTHORITIES

CASES	Page
<i>American Medical Ass'n v. United States</i> , 317 U.S. 519 (1943)	2
<i>American Medical Ass'n</i> , 94 F.T.C. 701 (1979), <i>aff'd as modified</i> , 638 F.2d 443 (2d Cir. 1980), <i>aff'd per curiam by an equally divided Court</i> , 455 U.S. 676 (1982)	2
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	<i>passim</i>
<i>Broadcast Music, Inc. v. Columbia Broadcasting Sys.</i> , 441 U.S. 1 (1979)	9
<i>FTC v. Indiana Fed'n of Dentists</i> , 476 U.S. 447 (1985)	9
<i>Group Life and Health Ins. Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979)	17, 18
<i>Jefferson Parish Hosp. Dist. Number 2 v. Hyde</i> , 466 U.S. 2 (1983)	18
<i>Medical Service Corp. of Spokane County</i> , 88 F.T.C. 906 (1976)	2
<i>National Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla.</i> , 468 U.S. 85 (1984)	9
<i>St. Paul Fire & Marine Ins. Co. v. Barry</i> , 438 U.S. 531, 541 (1977)	17
<i>Union Labor Life Ins. Co. v. Pireno</i> , 458 U.S. 119 (1981)	17, 18
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563, 570-71 (1966)	8

STATUTES

Health Maintenance Organization Act, 42 U.S.C. §§ 300e-300e-17	2
McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b)	<i>passim</i>
Sherman Act, 15 U.S.C. § 2	<i>passim</i>

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INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Group Health Association of America, Inc. ("GHAA") files this brief as *amicus curiae* in support of the petition for writ of certiorari.¹

GHAA, founded in 1959, is the largest national trade association of health maintenance organizations ("HMOs"). Its 270 member HMOs provide health benefits coverage for over 21 million people in the United States. GHAA's members include independent locally-based non-profit and for-profit plans, as well as HMO programs operated by national HMO firms, subsidiaries of Blue Cross and Blue Shield plans, and subsidiaries of major insurance organi-

¹ Letters of consent from the parties have been lodged with the Clerk of the Court.

zations.² Many are "qualified" under the federal Health Maintenance Organization Act, 42 U.S.C. §§ 300e-300e-17.

GHAA's member HMOs provide or arrange for health services in a number of ways. Some employ staff physicians. Some have contracts with medical group practices or associations of individually practicing physicians. Some contract directly with individual physicians. Others use a combination of these methods. All, however, provide or arrange for health care services through an established network of contracting physicians, in contrast to traditional indemnity benefit plans that cover services by all or almost all of an area's health care providers. Many HMOs use a "primary care physician" or "gatekeeper" approach to manage health care and help control its cost, whereby the member's family physician must give advance approval for referrals to specialists and hospitals. Risk-sharing arrangements are often used with physicians to encourage cost-efficient care. These may be "capitation" methods or a " withhold" system such as that used by petitioner Ocean State Physicians Health Plan ("Ocean State").

HMOs have historically faced the difficulty of entering and competing in health care financing markets historically dominated by health plans and insurers operating on a traditional indemnity basis, and have struggled with the long ingrained hostility to prepaid closed panel medical practice among segments of the medical community. See, e.g., *American Medical Ass'n v. United States*, 317 U.S. 519 (1943); *American Medical Ass'n*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided Court*, 455 U.S. 676 (1982); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976) (consent agreement). Because HMO members use the services of a limited panel of pro-

² Petitioner Ocean State Physicians Health Plan is not a member of GHAA. HMO Rhode Island, an affiliate of the respondent, is a member of GHAA.

viders who have agreed to negotiated price and medical review terms with the plan, HMOs have long posed a competitive threat to physicians practicing on the traditional "freedom of choice" fee-for-service basis, and to indemnity health plans and insurers whose reimbursement programs are structured to cover the services, and price structures, of substantially all the providers in a community.

HMOs entering a market dominated by one or more traditional indemnity benefits carriers must recruit an adequate panel of physicians to appeal to employers and potential subscribers. They must contract with these physicians to control the price and unnecessary utilization of health services, the critical determinants of the HMO's input costs. Once in operation, HMOs provide needed stimulus to health care markets where comprehensive insurance coverage makes most individual consumers relatively insensitive to price differences among providers, and the traditional "freedom of choice" insurance reimbursement environment has given little incentive to physicians to lower their fees.

HMOs have now achieved substantial success in many areas of the country. Consumers have responded favorably to the comprehensive benefit programs and high quality of care HMOs make available at rates that are commonly lower than traditional indemnity programs. The traditional indemnity payors are responding. Some are developing their own innovative programs and HMO operations. Others are trying to use their power to blockade the market and prevent HMOs from competing effectively.

Respondent Blue Cross and Blue Shield of Rhode Island ("Blue Cross") covered the majority of Rhode Island's private paying patients and had contracts with 90% of the physicians. It had monopoly power. With the stated purpose of sending a message to every physician in the state on the "implication of signing" with Ocean State and thereby, to paraphrase Blue Cross's president, castrate the HMO, Blue Cross declared that it

would reduce each physician's reimbursement to the lowest level charged by that physician to another payor. Describing this program as its "Prudent Buyer" policy, Blue Cross characterized as a 20% discount the withhold arrangements used by Ocean State as part of its risk-sharing and cost control incentive plan with its doctors.

The Ocean State doctors, especially those whose Blue Cross patients greatly outnumbered their Ocean State patients, were caught in an economic vise. Even though Ocean State was a well-positioned entrant, with sponsorship and ownership by its participating physicians, over a fourth of the HMO's doctors quit. It was forced to incur higher costs paying non-contracting physicians for services that would otherwise have been performed by physicians under contract to the HMO. Its panel of participating physicians, a key competitive attribute for HMOs in appealing to consumers, was significantly diminished.

At the same time, Blue Cross pressured employers not to deal with Ocean State. Most employers will not arrange solely for HMO coverage for their employees and their dependents because many beneficiaries are accustomed to having free choice of physician in their health plan and do not desire HMO coverage. In Rhode Island, moreover, Blue Cross's market power was reflected in the belief among many employers that they needed to offer Blue Cross coverage as an option for their employees, even if they offered alternative HMO coverage. Blue Cross exploited this power by adopting a policy of price discrimination, charging arbitrarily high premiums to employees who offered HMO coverage in addition to Blue Cross.

HMOs across the country are facing practices similar to those at issue in this case. Doctors who agree to participate in low cost HMOs are threatened with reduced reimbursement by powerful health carriers operating on the traditional indemnity insurance model. Some carriers are refusing to provide coverage to employers who also purchase HMO coverage. Others are willing to

provide coverage if the employer continues to offer HMO coverage, but will only do so at much higher rates than would otherwise be charged.

These practices can be legitimate competition on the merits when employed in a competitive market. However, their use by a monopolist can be devastatingly anticompetitive and without reasonable justification. The danger to competition in private health care financing markets is significant, posing the risk that the pro-competitive stimulus HMOs provide will be stifled in those markets where competition is most needed.

The court of appeals affirmed the trial court's overturning the jury verdict that Blue Cross had engaged in monopolization. It held that Blue Cross's policy of reducing reimbursement to doctors participating in Ocean State, as a matter of law, was not exclusionary. It also held that discriminatory pricing by Blue Cross was not coercion and therefore was exempt from antitrust scrutiny as the state-regulated "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b). The court's antitrust analysis was fundamentally unsound and invites similar anticompetitive conduct harmful to HMOs and to consumers in other health care markets across the country.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case presents two issues critical to antitrust jurisprudence generally and to the vitality of competition in health care financing and delivery. First, the case presents a significant opportunity for the Court to address application of Section 2 of the Sherman Act, 15 U.S.C. § 2, to the use of a monopolist's market power to drive up the input costs of a new rival, where the monopolist's conduct also reduces its own costs. Second, it provides the Court a chance to resolve what conduct in the business of insurance constitutes "coercion" and is therefore subject to the Sherman Act, notwithstanding the anti-

trust immunity provided by the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b).

II. THE COURT BELOW GAVE IMPROPER CONCLUSIVE EFFECT TO THE EXISTENCE OF COST SAVINGS FOR BLUE CROSS

The court of appeals' construction of Section 2 would permit a monopolist, *as a matter of law*, to secure its monopoly position through any competitive conduct that saves the monopolist money, regardless of its effect on consumers and competitors and in utter disregard of the availability of less restrictive alternatives and of the monopolist's stated intention to destroy its competition by raising a competitor's costs. This ruling tips the balance in Section 2 analysis far beyond giving due consideration to legitimate efficiency-enhancing effects of a monopolist's market behavior. Instead, it improperly creates a virtual *per se* rule of legality, making the existence of any efficiency justification a complete defense for exclusionary conduct.

Blue Cross is a monopolist in the Rhode Island health care financing market. It has participation contracts with more than 90% of the practicing physicians in the state. It covered a great majority of the privately insured population. Petitioner Ocean State was a new entrant HMO seeking to compete against Blue Cross's dominance. It needed to secure and maintain participation agreements with a limited, but sufficient-sized, panel of physicians who would agree to reimbursement and utilization management terms that would permit the HMO to price its health care coverage competitively with Blue Cross.

One means used by Ocean State and other HMOs to control costs is to include "withhold" and "bonus" provisions in their contracts with participating physicians. Under these arrangements, a portion of the physician's fee is withheld, but returned by the HMO if its budget allows once expenses for the year are calculated. In

addition, under Ocean State's specialty incentive pool program ("SIPS"), which commenced before the Prudent Buyer program went into effect, any savings from budget allocations for expenses in each of the various medical specialties are also payable as bonus distributions to the specialists.

These devices serve two purposes. They give the participating physicians incentives, absent in the traditional fee-for-service system, to control unnecessary utilization of health care services. Further, availability of the withhold to offset higher than expected health care costs permits the HMO to reduce its net expenses.

After Ocean State had made inroads into Blue Cross's market share and Blue Cross had incurred some financial losses, Blue Cross decided to strike back. It adopted a "Prudent Buyer" policy under which payments to a physician would be reduced to the lowest fee charged by the doctor to any other payor. Blue Cross treated the "withhold" reductions by Ocean State as a discount, so it announced it would reduce fees payable to Ocean State doctors by 20%.

Ocean State's physicians faced the unhappy prospect of receiving 20% less for their services for the bulk of their patients (those covered by Blue Cross) or giving up the lesser number of patients they covered through Ocean State. Where Ocean State members were a small percentage of a doctor's practice, the economic pressure on the physician to quit Ocean State was severe. A quarter of them did quit, resulting in Ocean State having to pay for services from non-participating physicians at much higher rates than it had previously paid participating physicians. This hindered Ocean State's efforts to diminish Blue Cross's market dominance through vigorous price competition in premiums beneficial to consumers.

The "Prudent Buyer" policy was adopted, according to the Blue Cross official responsible for its implementation, to send a message to every doctor in the state

about the financial implications of contracting with Ocean State. It was adopted, as the court below paraphrased Blue Cross's president, to literally "emasculate" Ocean State. Pet. 24a.

The jury found that Blue Cross had engaged in monopolization. The trial judge granted judgment notwithstanding the verdict, and the court of appeals affirmed.

A. The Court of Appeals Misapprehended or Grossly Misapplied the Proper Standard For Assessing Whether Blue Cross's Prudent Buyer Policy Was Exclusionary by Failing to Consider Whether the Policy Was Unnecessarily Restrictive of Competition.

Section 2 of the Sherman Act condemns the "willful" maintenance of monopoly power. *See United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). This "willfulness" standard requires that monopolizing conduct be "exclusionary," which the court below defined as behavior that:

not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way. Pet. 18a.

See Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605 n.32 (1985), quoting 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78.

The court did not contest that the evidence permitted a conclusion that the Prudent Buyer policy did tend to "impair the opportunities" of Ocean State. Nevertheless, it concluded that Prudent Buyer was a "bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services." Pet. 18a. Such a policy, the court found, "tends to further competition on the merits and, *as a matter of law*, is not exclusionary." Pet. 19a (emphasis added).

The court jettisoned the very standard for identifying "exclusionary" conduct that it had enunciated, that be-

havior which furthers "competition on the merits" can be exclusionary if it does so "*in an unnecessarily restrictive way.*" (emphasis added). The court's analysis abandoned this critical component of the standard. Scrutiny of a practice's effects and character under Section 2 cannot cease merely upon finding that conduct reduces the monopolist's costs and thereby theoretically furthers "competition on the merits."

Following the reasoning adopted by the court below, a monopolist could lawfully force all the suppliers in a market to sign exclusive contracts if this would assure responsive service and achieve other benefits that would save it money. Similarly, a monopolist might decide that acquiring its only competitor would achieve some incremental savings. Section 2 does not sanction such conduct by a monopolist merely upon a showing that the conduct reduces the monopolist's costs and thereby furthers competition on the merits.

Rather, sound antitrust analysis would plainly require, if such practices were not condemned outright, that the exclusionary character of those actions be assessed taking into account both their anticompetitive and procompetitive aspects. Once the practices were shown to impair the opportunities of the monopolist's competition, any procompetitive efficiency benefits would be considered in light of long-term effects on consumers and of alternative means of cost-saving open to the monopolist that would be less restrictive of competition. The court could, moreover, properly rely on intent evidence to inform its judgment about the exclusionary character of challenged conduct.³

³ Application of Section 2 analysis in this manner would be consistent with the approach under the rule of reason set forth by this Court for Sherman Act, Section 1 matters. See *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1985); *Nat'l Collegiate Athletic Ass'n v. Board of Regents of Univ. of Okla.*, 468 U.S. 85 (1984); *Broadcast Music, Inc. v. Columbia Broadcasting Sys.*, 441 U.S. 1 (1979).

The court of appeals did not explore whether the jury could have reasonably found that Blue Cross had sufficient alternative means of reducing its costs in response to Ocean State's competition. Nor did the court assess whether the policy was unnecessarily restrictive of competition by weighing the practice's procompetitive benefits against its anticompetitive effects. The court focused on Blue Cross's cost savings in those instances where doctors remained in both programs, but gave no weight to the fact that the Prudent Buyer policy induced doctors to quit Ocean State. These resignations, foreseen and intended by Blue Cross, drove up Ocean State's costs without reducing Blue Cross's.

Instead, the court below reformulated the issue. The court stated, "Even a monopoly can engage in a competitive course of conduct, so long as it does so for valid business reasons (such as the desire to get the lowest possible price), rather than in order to smother competition." Pet. 21a. This formulation ignores the "unnecessarily restrictive" of competition component of the analysis and precludes balanced assessment of the competitive effects of the monopolist's conduct. Apart from a circular and unsound analysis of the intent evidence, the court's consideration of the character and competitive effects of Blue Cross's conduct effectively ceased with its observation that the Prudent Buyer policy was an effort to reduce Blue Cross's costs.

B. The Court of Appeals Misapprehended the Role of Intent Evidence in Determining Whether Blue Cross's Conduct Was Exclusionary.

The court indicated that "competitive" conduct by a monopolist is permissible regardless of its effect on the competition, so long as it is engaged in for "valid business reasons" and not to "smother competition." Pet. 21a. The court sought to overcome striking evidence that the Prudent Buyer policy had been adopted with the knowledge and intent that it would harm—indeed emasculate—Ocean State by driving up its input costs. The court explained away this evidence, insisting that

the intention to make a competitor "disappear" is "irrelevant" so long as the conduct is "legitimate." Pet. 24a. The court reasoned further that lowering Blue Cross's costs was, *ipso facto*, legitimate and therefore that the Prudent Buyer policy was supported by valid business reasons. The result of this circuitous inquiry was that the "desire to crush a competitor," Pet. 24a, would not be relevant in determining whether the monopolist intended to "smother competition." Pet. 21a.

The court was correct, of course, that an intention to prevail over, or destroy, one's competition is not evidence of anticompetitive intent or invalid reasons for competitive conduct. The court lost its way in this discussion, though, by failing to focus on *how* Blue Cross as a monopolist intended to crush its competition--by reducing its own costs so it could charge lower premiums, or by raising Ocean State's costs. If Blue Cross intended to defeat Ocean State through reduced premiums after it had reduced its own expenses, the court's reasoning on this point might not have been so far off the mark. In fact, Blue Cross did not reduce its premiums.

Rather, the actual and intended harm to Ocean State was increased costs and reduced appeal to consumers caused by resignation of so many of its participating physicians. Apart from its president stating in colorful language that Blue Cross intended to castrate Ocean State, the Blue Cross official charged with implementing the Prudent Buyer program had emphasized that "not one guy *in the state isn't going* to know the implication of signing with Ocean State." Pet. 24a (emphasis in original). The jury quite properly relied on the direct and inferential evidence of Blue Cross's intent in concluding that the predominant character of the Prudent Buyer policy was to suppress competition.

C. The Prudent Buyer Policy Was Not a Means to Achieve the Same Low Price Charged to a Competitor.

Ocean State's purchasing arrangements with physicians provided for initial payments to the physicians at

a lower rate than Blue Cross was paying, since a percentage of the fee payable to the doctor was withheld by Ocean State. From an economic and antitrust analysis standpoint, that reduction was not a true 20% price discount.

First, in any given year, some or all of a physician's withhold might be returned to him. Second, under the Ocean State SIPS program put in place before the Prudent Buyer program went into effect, the doctors were also eligible to receive bonus payments from Ocean State in addition to return of their withhold fees if the HMO achieved adequate savings on health care costs in their specialty. Thus, the withhold arrangements were the flip side of an "upside" potential for the doctors. Third, the doctors were the shareholders of Ocean State, so that any profits from its operations would inure to their benefit. Finally, doctors might be willing to give a lower price to Ocean State than to Blue Cross in the hope that Ocean State would eventually erode Blue Cross's market share and produce a more competitive health care financing market. This would result in more competition for their services, and a better price and quality package for consumers. While the compensation arrangements the physicians had with Ocean State would presumably have met their marginal costs for the extra patients brought to them by the HMO, even if they never received their withheld fees, reimbursement at a 20% lower rate by Blue Cross could well have resulted in insufficient overall practice revenues for some Ocean State doctors to cover their total costs.

Thus, Blue Cross's blanket reduction of 20% from the fees payable to Ocean State physicians did more from an economic standpoint than ensure that it paid as low a price as Ocean State. It gave those physicians an even lower effective price than the effective price paid by Ocean State.

D. The Court of Appeals Erred in Declaring That the Prudent Buyer Policy Could Not Be Exclusionary if Blue Cross's Payments to Physicians Were Not "Predatory" or "Below Cost."

The court of appeals found that so long as the price being paid to the doctors was not "predatory" or "below cost," the Prudent Buyer policy could not be exclusionary. Pet. 19a. This incorporation of monopoly pricing principles into an assessment of Blue Cross's monopoly purchasing behavior was erroneous. Predatory pricing theory deals with below-cost sales to customers that a monopolist's weaker competitors cannot afford to match. The analogy in monopoly purchasing would be a firm paying a price to its suppliers that was so high that the purchaser could only recoup its costs if it could sell at monopoly prices in the long run by drying up the sources of supply to its competition.

Traditional predatory pricing (or buying) analysis, however, is inappropriate here. Blue Cross was not necessarily paying excessively high prices to suppliers to foreclose their availability to competitors. This monopolist was punishing suppliers for giving perceived discounts to the competition. That the monopolist might save money in doing so is no absolute defense.

Predatory below-cost pricing by a monopolist, whatever standard for application of that label is adopted, is presumptively anticompetitive because the prices being charged are so low as not to make business sense absent an exclusionary effect that will permit the perpetrator to later recoup its costs through an exercise of monopoly power. Thus, there is no need to balance the particular procompetitive and anticompetitive effects of the practice once pricing has been determined to be predatory. It is for this reason that the standard of proof to establish predatory pricing is so high, and why there has been so much debate in the case law and academia on its true parameters.

Here, in contrast, there is no predatory pricing (or, by analogy, "predatory buying" at high prices to foreclose supply). Thus, it is critical to make the competitive effects analysis that the standard articulated by the court below calls for, but which the court failed to do—determining whether the "competition on the merits" that impairs opportunities of competitors is unnecessarily restrictive of competition. A plausible or colorable efficiency justification for a challenged practice removes the conclusive presumption of illegality that applies to truly predatory pricing, but does not mark the end of the analysis of competitive effects. This Court has never ruled that the presence of any efficiency justification is sufficient to make *per se* lawful a monopolist's practice which injures competitors. *Cf. Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 604 (1985) (business success that "reflects only a superior product, a well-run business, or luck" is not monopolization) (emphasis added).

E. The Prudent Buyer Policy Was Unnecessarily Restrictive of Competition.

In a competitive market, one buyer might contract with a supplier to adjust the price if the supplier sells to another buyer at a lower price. The buyer and seller in the competitive market are incapable of affecting or dictating the "market" price. The inclusion of a "lowest price" clause in the contract can be a means of ensuring to the extent possible, given changes in the market over time and lack of perfect information when the contract is signed, that their transactions are conducted at the "market price."

A buyer with market power, in contrast, has the power to set price.⁴ Such a buyer has no comparable

⁴ There is solid evidence here that Blue Cross had market power not only as a seller of health coverage, but also as a purchaser of physician services. For example, Ocean State doctors faced with the loss of Blue Cross's subscribers would find it extremely hard

need to adapt its business dealings to the market. Its actions can determine the market price. It can protect itself from overcharge through exercise of its own purchasing power. It can force below competitive levels of payment on its suppliers if it so chooses.

Indeed, Blue Cross had a multitude of choices. For example, it could have determined what level of fee reductions it needed to reduce costs and compete more effectively with Ocean State. It could then have directly sought such price reductions from its physician suppliers, without tying the price reduction to whether the individual doctor was charging a particular price to Ocean State or anyone else.

Blue Cross may have already exploited its available power to require physicians to provide the lowest price that Blue Cross could reasonably require, without degrading the quality of the service the doctors provided below a level satisfactory to Blue Cross and its customers. Commencing to pay them less would be "predatory" as to the physicians. If that was the situation when Blue Cross imposed the Prudent Buyer policy, it was using its power to force at least some of its suppliers to raise their price to, or cease dealing with, Ocean State.⁵

to compete in any realistic time period for enough additional patients to replace them. Most other patients are covered by governmental or commercial health benefit programs that will reimburse any provider. Since fees payable are either regulated or paid almost in full by the payor, reduction in fees is not normally a viable means for a doctor to attract substantial numbers of new clients, other than through contracts with managed care plans such as HMOs which cover only a limited portion of the population. Doctors who continued with Ocean State risked losing a great portion of their practice income with no prospect of quick recoupment.

⁵ If Blue Cross was already paying a monopsony price, then its insistence on cutting the rates by 20% for those contracting with Ocean State would appear presumptively unreasonable in its effects on Ocean State.

Or, as petitioners have suggested, Blue Cross may have been paying its physician contractors more than it needed to. In that case, its failure to directly seek price reductions across the board from its participating physicians in response to competition from Ocean State itself manifests selection of a policy that would obstruct Ocean State's efforts to lower its costs, and rejection of a simple strategy that would have served more directly to reduce Blue Cross's own costs. Blue Cross's strategy saved it money for services by doctors who stayed with Ocean State, but served only to raise Ocean State's costs with respect to the many doctors who Blue Cross could foresee would, and in fact did, quit Ocean State.⁶

There may, no doubt, be economic theories which could be articulated that would purport to vindicate the course Blue Cross elected as enhancing competition. Here, though, Blue Cross's exercise of market power was anti-competitive and unreasonable by the standard logic of antitrust law and economics, since it was an attempt to exclude a rival "on some basis other than efficiency." *See Aspen Skiing*, 472 U.S. at 605. In any event, the court of appeals erred in concluding that a reasonable jury, as a matter of law, could not find that the record established exclusionary conduct.

III. THE COURT OF APPEALS TOO NARROWLY CONSTRUED THE EXCEPTION FROM ANTI-TRUST IMMUNITY UNDER THE McCARRAN-FERGUSON ACT FOR ACTS OF COERCION

Part of Blue Cross's strategy to destroy its competition was a price discrimination scheme. Employers who chose to buy coverage from both Ocean State and Blue Cross were charged arbitrarily higher premiums by Blue

⁶ Indeed, if doctors had not quit Ocean State, but all (or all but a few) had agreed to lower their prices to Blue Cross, there would be no monopolization here. There would merely be a procompetitive reduction in costs. Blue Cross knew, and the economics of the market dictated, that a large number of the doctors would not stay in both programs and would quit Ocean State.

Cross than those who dealt only with Blue Cross.⁷ Blue Cross could impose arbitrary premium differentials because of its market power. Rhode Island employers commonly feel they have to offer Blue Cross even if they also offer HMO coverage. Although price differentials based on a health plan's degree of penetration in an employer account can be competitively reasonable and actuarially justified, their use here by Blue Cross was unjustifiably coercive and anticompetitive.

The court below found that Blue Cross's pricing discrimination was exempt from antitrust scrutiny under the McCarran-Ferguson Act, notwithstanding the exception from immunity under that Act for acts of "coercion." 15 U.S.C. § 1013(b). Since its passage in 1945, the McCarran-Ferguson Act has been the subject of numerous court battles regarding its scope in exempting conduct from antitrust scrutiny. This Court has repeatedly emphasized that this exemption from the antitrust laws is to be narrowly construed. See, e.g., *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1981); *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

In *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 541 (1977), this Court made clear that the exception from McCarran-Ferguson Act immunity for "boycotts" was to be construed consistent with the traditional meaning of the term boycott in antitrust jurisdiction. Although little precedent has arisen regarding the scope of the exception from McCarran-Ferguson Act immunity for "acts of coercion," the same approach for construing the term "coercion" should apply.

The court below found that the price differentials imposed by Blue Cross were not coercion. It said the record lacked evidence that any employer was coerced not to

⁷ It involved in this scheme a Blue Cross subsidiary HMO evidently established without prospects for its own business success, but which would be used in undermining Ocean State.

offer Ocean State to its employees. Pet. 16a. The court discounted evidence regarding one employer by pointing out that Blue Cross's actions did not leave the employer with "no choice." Pet. 16a. The court continued, "He merely faced rate increases that were somewhat greater than they otherwise would have been." The court applied an erroneous standard in assessing whether the record established coercion.

Congress chose to use the phrase "acts of . . . coercion" in the McCarran-Ferguson Act, and not "refusals to deal" or "exclusive dealing." Unilateral insistence that a customer either do business with the offeror or with a competitor, but not with both, is generally neither coercive nor anticompetitive when employed by a firm without market power. Thus, for example, a tie-in arrangement is not "coercive" where there is no market power. *See Jefferson Parish Hosp. Dist. Number 2 v. Hyde*, 466 U.S. 2 (1933). "Coercion," in contrast, connotes forced imposition of terms of dealing through exertion of economic power. This could obviously reach a great many things done by a monopolist, but that is no reason to adopt a narrower construction of the term.

Petitioners have suggested "coercion" could be construed to reach only coercive *anticompetitive* conduct. Pet. 25. Such a reading is narrower than necessary. Thus, a monopolist might threaten to refuse to deal with a customer unless it agreed to pay the monopolist's high prices. This could be coercion, but it would not be anticompetitive, since it would not maintain the monopolist's market power and thus would not violate any provision of the antitrust laws. There is no reason, though, to construe the "coercion" exception from McCarran-Ferguson Act immunity as only applying to conduct unlawful under the Sherman Act. As this Court stated in *Pireno*, "It is axiomatic that conduct which is not exempt from the antitrust laws may nevertheless be perfectly legal." 458 U.S. at 126 (quoting *Group Life and Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 210 n.5).

Where a monopolist uses its power to force customers to choose between even higher prices and refusing to purchase from any other supplier, this conduct can be as coercive as if the monopolist had simply threatened to refuse to deal altogether with customers who continue to purchase from any other supplier. Identifying an absolute refusal to deal as coercion, but not the equally threatening imposition of disadvantageous trade terms on the customer who chooses not to deal exclusively with the monopolist, is to miss the essence of coercion's meaning in economic terms.

The critical inquiry in determining whether conduct is coercion is to determine if its imposition involves an exercise of market power. If the pricing differentials in fact were actuarially justified, for example, then their use would not have been a manifestation of market power. Whether there was sufficient evidence to show that the price differentials were so unjustified as to be coercive and monopolistic is a question to be determined on the basis of the record, in accordance with an appropriate legal standard. That legal standard should not be an insistence that the target employer must have been left without any choice in the matter.

It is no refutation of the existence of monopoly power or of its coercive exercise that a customer could choose to deal with others rather than the monopolist, at great added expense. Given the finding that Blue Cross had monopoly power, the court of appeals committed plain error in holding that charging unreasonably discriminatory prices to customers who will not deal exclusively with the monopolist could not be found to be coercion.

CONCLUSION

The decision of the court of appeals sets an extremely damaging precedent in the field of health care and in antitrust law generally. That court's decision provides sweeping exculpation of anticompetitive conduct by a monopolist so long as the conduct saves the monopolist

money, regardless of the conduct's anticompetitive effects, long-term injury to consumers, the monopolist's intent to destroy competition by forcing increases in a competitor's costs, and the existence of alternative means of cost reduction for the monopolist. The decision also applies an erroneous standard for determining whether conduct by a monopolist, short of an absolute refusal to deal, can be found to be "coercion" outside the scope of the McCarran-Ferguson Act antitrust exemption.

Unless reviewed by this Court, this decision will provide comfort and reassurance to other firms in the health care delivery and financing industry engaging in similar behavior. The resulting loss of competition will be manifested in higher prices and lower quality of health care benefits in the future. The writ of certiorari should be granted to review the judgment of the United States Court of Appeals for the First Circuit.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS
HEALTH PLAN, INC., ET AL.,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE
FIRST CIRCUIT

**BRIEF OF U.S. HEALTHCARE, INC.
AS AMICUS CURIAE
IN SUPPORT OF THE PETITIONERS**

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICUS CURIAE	1
REASONS FOR GRANTING THE WRIT	6
I. INTRODUCTION	6
II. THE DECISION OF THE COURT OF APPEALS PORTENDS SERIOUS CONSE- QUENCES FOR THE NATION'S HEALTH CARE AND CONSTITUTES A RADICAL DEPARTURE FROM LONG-STANDING SHERMAN ACT JURISPRUDENCE	7
A. THE COURT OF APPEALS DEVI- ATED FROM CONSISTENT SHERMAN ACT PRECEDENT AND SANCTIONED MONOPOLIZATION	8
B. THE PUBLIC INTEREST WILL BE HARMED IF THE COURT OF APPEALS' DECISION IS LEFT UNDISTURBED	11
CONCLUSION	15

TABLE OF AUTHORITIES

CASES	Page(s)
<i>Apex Hosiery Co. v. Leader</i> , 310 U.S. 469 (1940)	9
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	9
<i>Braen v. Pfeifer Oil Transportation Co.</i> , 361 U.S. 129 (1959)	8
<i>Kartell v. Blue Shield of Massachusetts</i> , 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985)	10
<i>Lorain Journal Co. v. United States</i> , 342 U.S. 143 (1951)	9
<i>Northern Pacific Ry. Co. v. United States</i> , 356 U.S. 1 (1958)	9
<i>Standard Oil Co. of Cal. v. United States</i> , 337 U.S. 293 (1949)	9
<i>United States v. Griffith</i> , 334 U.S. 100 (1948)	10
<i>United States v. Grinnell Corp.</i> , 384 U.S. 563 (1966)	9, 10
<i>United States v. Philadelphia National Bank</i> , 374 U.S. 321 (1963)	9
<i>United States v. Standard Oil Co.</i> , 221 U.S. 1 (1911)	13
<i>United States v. United Shoe Mach. Co.</i> , 110 F. Supp. 295 (D. Mass. 1953), aff'd per curiam, 347 U.S. 521 (1954)	9, 10, 11

STATUTES

Health Maintenance Organizations Act	
42 U.S.C. § 300e	3
42 U.S.C. § 300e-1	3
42 U.S.C. § 300e-9	11
42 U.S.C. § 300e-10	12

CASES	Page(s)
Sherman Act	
Section 2, 15 U.S.C. § 2	9
MISCELLANEOUS	
Altman, <i>Changes in Medicine Bring Pain to Healing Profession</i> , N.Y. Times, February 18, 1990 at A1, col. 4	5, 6
Krattenmaker and Salop, <i>Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price</i> , 96 Yale L.J. 209 (1986)	8, 13
2 E. Kintner, <i>Federal Antitrust Law</i> (1980)	13
Los Angeles Times, February 3, 1990 at A2, col. 1	7
Proprietary to the United Press International, <i>Administration Plans New Antitrust Effort</i> , December 14, 1989	7

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

No. 89-1044

OCEAN STATE PHYSICIANS
HEALTH PLAN, INC., et al.,

Petitioners,

v.

BLUE CROSS AND BLUE SHIELD
OF RHODE ISLAND,

Respondent.

ON PETITION FOR A WRIT OF
CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIRST CIRCUIT

**BRIEF OF U.S. HEALTHCARE, INC.
AS AMICUS CURIAE
IN SUPPORT OF THE PETITIONERS**

INTEREST OF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, U.S. Healthcare, Inc. ("U.S. Healthcare") files this brief as *amicus curiae* in support of the petition for writ of certiorari.¹

U.S. Healthcare, through subsidiaries, owns and operates health maintenance organizations ("HMOs") in certain northeastern states. In its markets, U.S. Healthcare's HMOs primarily compete with long-entrenched Blue Cross and Blue Shield indemnity insurance plans.

The decision of the Court of Appeals constitutes not only a marked departure from existing antitrust law, it

1. Letters of consent from both parties have been lodged with the Clerk of the Court.

validates a plan for monopolization in an important segment of the health care industry. If the decision of the Court of Appeals is permitted to stand, the exclusionary pattern adopted by Blue Cross and Blue Shield of Rhode Island may be replicated by the dominant plans in other markets, enabling them to maintain their supremacy by stifling beneficial competition. In particular, U.S. Healthcare could easily become the next intended victim of the same type of blatant anti-competitive scheme that victimized Ocean State here. More importantly, the Court of Appeals' decision permits entrenchment of outmoded health care monopolists, a result that will ultimately increase the already rampant inflation in health care costs by discouraging competition and innovation. Left unchecked, this static monopolization will exacerbate the nation's health care crisis and result in the denial of care to those who cannot afford higher costs.

The HMOs operated by U.S. Healthcare generally are qualified under the provisions of the Health Maintenance Organizations Act of 1973, 42 U.S.C. § 300e *et seq.* ("HMO Act"). The HMO Act articulates Congress' intent to foster the growth of HMOs as an alternative to the traditional form of health care indemnity insurance epitomized by Blue Cross and Blue Shield.

The benefits available to the members of U.S. Healthcare's HMOs are significantly different from those provided by traditional health insurance, which covers medical care on a fee-for-service basis. Physicians submit bills and are paid a portion of the cost of the services by the insurer. In addition to monthly premiums, members are required to contribute a substantial deductible that may average approximately twenty percent (20%) for some services and higher for others. Some services, such as routine preventive check-ups, are often not covered at all. The principal attraction of the traditional plans is that they offer unlimited physician choice in the form of partial reimbursement to the member for the costs of certain physician services.

In contrast, U.S. Healthcare's HMOs provide comprehensive benefits, including: (1) physician services (including consulting and referral services); (2) inpatient and outpatient hospital services; (3) medically necessary emergency health services; (4) short-term mental health services; and (5) medical treatment and referral services for the abuse of or addiction to alcohol and drugs. 42 U.S.C. § 300e-1(1). Physician care services are provided to members by independent private physicians who contract with U.S. Healthcare. 42 U.S.C. § 300e(b)(3). The care is provided in the offices of the participating primary and specialist physicians, not in a facility established by the HMO.²

Under the U.S. Healthcare model, participating primary care physicians are not paid on a fee-for-service basis. Rather, they are paid according to a method known as "capitation." The capitation system pays the physician an amount at periodic intervals for each member who has selected that physician regardless of whether the particular patient seeks any health care during the period. The frequency and size of capitation payments depend on various factors, including the quality of care. The fundamental principle underlying this method of compensation is to provide physicians with a financial incentive to keep their patients healthy.

Physician services are covered in full by the HMO except for nominal copayments for primary care physician visits. Medically necessary visits to specialists and hospital stays are covered in full when authorized by the primary care physician, while medically necessary emergency treatment is reimbursable less a modest copayment. Many members also opt for prescription coverage which pays for most

2. Amicus Kaiser Permanente, by contrast, provides health care to its members by physicians who practice solely for the HMO at facilities owned and operated by Kaiser. See Brief of Kaiser Foundation Health Plan, Inc. as Amicus Curiae in Support of Petitioners at 2.

prescription drugs less a small copayment. This model lowers the financial barrier to quality, comprehensive and coordinated care.

The public interest, as articulated in the federal HMO Act and various state statutes, demanded more cost-effective and comprehensive health care coverage. The HMO Act implicitly recognized that the traditional indemnity plans were not adequately meeting the needs of society. The stark contrast between HMOs and traditional indemnity plans can best be understood by comparing the physician compensation methods. U.S. Healthcare's HMOs pay their participating physicians in a manner that encourages them to foster patient health. However, by compensating on a fee-for-service basis, the traditional indemnity plans give physicians a financial incentive to provide more care than is necessary. The lack of any coordination of care also creates waste and inefficiency.

U.S. Healthcare's HMOs provide more benefits for each premium dollar. Health and wellness are fostered through care that is more comprehensive than that covered by traditional indemnity plans. HMOs are often an attractive choice for younger subscribers, who ordinarily have not yet developed particular physician relationships, because it is both more affordable and comprehensive. *See Ocean State Physicians Health Plan, Inc.*, 692 F. Supp. 52, 59 (D.R.I. 1988) (discussing Blue Cross & Blue Shield's fear that younger subscribers would "adversely select" Blue Cross in favor of an HMO). Furthermore, where HMOs compete successfully, they attract sufficient numbers of physicians to offer a choice that compares favorably with that of the traditional plans. The dramatic growth of HMO enrollments in markets where they are not subject to unfair predation demonstrates clearly that HMOs meet the public's need for affordable, comprehensive, quality health care. Indeed, U.S. Healthcare's HMOs presently have approximately 1,070,000 members, up from 794,000 at the end of 1987.

Like Ocean State, U.S. Healthcare is extremely vulnerable to predatory and exclusionary conduct by the dominant plans. Blue Cross type plans generally offer unlimited physician choice, while HMOs, especially in their start-up stage, cannot offer the same breadth of choice. More importantly, the Blue Cross type plans have been the dominant health care insurers in most areas for over fifty years. The Blue Cross plans have the power to influence employers' decisions since employers are reluctant not to offer their employees at least one unlimited physician health care plan. Physicians are also susceptible to coercion since they are unlikely to flout the number one "purchaser" in the market. Blue Cross type plans are capable of excluding competitors by exerting pressure at both the financing and purchasing ends of the health care spectrum. HMOs operated by Blue Cross plans have many of these same economic tools at their disposal.

The issue of health care costs is an increasingly pressing issue for this nation, particularly as the population grows statistically older. Health care expenditures now amount to almost twelve percent (12%) of the gross national product, making the health care field one of the most significant in the American economy.³ As the HMO Act implicitly recognized, one effective way to combat soaring health care costs is to nurture competition in the industry. Competition engenders efficiency and cost-effectiveness while maintaining a high level of quality. Such nurturing cannot take place where the dominant force in the market has the power literally to nip the competition in the bud by effectively denying it the ability to build a physician

3. In 1987, total health spending was \$500.3 billion or 11.1 percent of the gross national product. It is estimated that health care spending will increase to 12.0 percent of GNP in 1990. This contrasts with health-care's 5.9 percent share of GNP only twenty-five years ago. Altman, *Changes in Medicine Bring Pain to Healing Profession*, N.Y. Times, February 18, 1990, at A1, col. 4 (hereafter "Altman").

network and to construct upon that platform an economically viable enrollment. Absent a physician network, no HMO can compete for employers or members.

As with Ocean State, the ability of U.S. Healthcare to compete in new markets depends upon physician participation. The decision of the Court of Appeals blocks competitors' access to eligible physicians and insulates from antitrust liability precisely the type of exclusionary conduct that the Sherman Act was designed to prevent. The Court below permitted the monopolist to maintain monopoly power at a time where the needs of society demand progressive changes in the health care system fueled by fair competition. Moreover, the effect of this conduct flies in the face of federal policy to foster the growth of HMOs as expressed in the HMO Act. Accordingly, U.S. Healthcare submits this brief as *amicus curiae* in support of the petition for certiorari to underscore the significance that this case holds both for the health care industry and health care consumers.

REASONS FOR GRANTING THE WRIT

I. INTRODUCTION

This case presents one central issue for this Court's consideration. The nation is faced with a crisis in the cost and quality of health care.⁴ Yet the decision of the Court of Appeals sanctions a veritable blueprint for monopolization. The decision permits those plans that have dominated the markets for health care since the Great Depression to maintain their stranglehold by engaging in intentionally exclusionary conduct designed to stifle incipient competi-

4. Dr. Louis W. Sullivan, Secretary of Health and Human Services, recently remarked on the health care crisis, noting that: "[w]e've known for 15 years that we've had rising costs and that if things were not done to bring them under control there would come a day when there would be a reaction . . . We've reached that point." Altman at A35, col. 1.

tion from necessary alternatives, such as HMOs. Specifically, the petition for certiorari asks whether public policy and long-standing Sherman Act jurisprudence can countenance monopolistic behavior that can only have adverse effects on American health care.⁵ The issues presented in the petition are of vital importance to the public and are deserving of resolution.

II. THE DECISION OF THE COURT OF APPEALS PORTENDS SERIOUS CONSEQUENCES FOR THE NATION'S HEALTH CARE AND CONSTITUTES A RADICAL DEPARTURE FROM LONG-STANDING SHERMAN ACT JURISPRUDENCE

Both the District Court and Court of Appeals recognized that Blue Cross and Blue Shield of Rhode Island ("Blue Cross") held monopoly power with a market share in excess of eighty percent (80%). *See Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101, 1110 (1st Cir. 1989). Blue Cross had contracts with more than ninety percent (90%) of the physicians in Rhode Island. Blue Cross controlled the market from both ends, both as a "supplier" of physician services to employers who purchased health benefits coverage and as a "purchaser" of physician services for the patient population.

5. In recognition of the pressing issues facing the health care industry, the Justice Department has singled out the industry for particular scrutiny under the antitrust laws. *See L.A. Times*, February 3, 1990 at A2, col. 1. The health care industry was to be targeted because the industry is one of the "most important segments of our economy. . ." and there are indications that anti-competitive practices are taking place that run up costs significantly. Proprietary to the United Press International, *Administration Plans New Antitrust Effort*, December 14, 1989.

Notwithstanding Blue Cross' dominance, Ocean State enjoyed remarkable success in the few short years after it entered the Rhode Island market. Ocean State gathered a ten percent (10%) market share in two years along with a strong level of physician support. As a result of its innovations, Ocean State was able to offer consumers a benefit package that was fifteen percent (15%) broader than the Blue Cross package, at a price that was five percent (5%) to seven percent (7%) lower.

To counteract the damage to its business and stop the inroads that Ocean State was making into the Rhode Island market, Blue Cross developed a three-pronged plan of attack. This brief addresses only the third prong known as the "Prudent Buyer" policy. Pursuant to this policy, Blue Cross announced that it would pay no more for a physician's services than the physician was accepting from any competitor of Blue Cross. U.S. Healthcare supports the petitioner's belief, and the opinion of the properly instructed jury below, that this program was a deliberate, exclusionary effort to reduce competition in the Rhode Island health care market.

A. The Court of Appeals Deviated from Consistent Sherman Act Precedent and Sanctioned Monopolization

Where a decision of a Court of Appeals is in conflict with applicable decisions of this Court, review upon a writ of certiorari is appropriate. *See Braen v. Pfeifer Oil Transportation Co.*, 361 U.S. 129, 130 (1959). In the present case, the decision of the Court of Appeals sanctions "undue, unfair, or anti-competitive exclusion of rivals" by the dominant competitor in the Rhode Island health care field. *See Krattenmaker and Salop, Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209, 219 (1986) (synthesizing policy underlying this Court's leading antitrust decisions). Such a result directly

conflicts with the opinions of this Court which have consistently refused to condone exclusionary monopoly behavior.⁶

The conduct of Blue Cross in Rhode Island exhibits both of the necessary elements of the offense of monopoly under Section Two⁷ of the Sherman Act: (1) possession of monopoly power in the relevant market; and (2) willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident. *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966). The Court of Appeals decision transforms the monopolist's ability to willy-nilly quash smaller competition into "business acumen." This is contrary to the intent underlying the anti-trust laws.

On the basis of this two-step test, this Court consistently has condemned monopolistic conduct having the effect of excluding competitors from markets. See, e.g., *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985); *Lorain Journal Co. v. United States*, 342 U.S. 144 (1951); *Standard Oil Co. of Cal. v. United States*, 337 U.S. 293 (1949); *United States v. United Shoe Mach. Co.*, 110 F. Supp. 295 (D. Mass. 1953), *aff'd per curiam*, 347 U.S. 521 (1954). Yet, despite this clear antipathy toward willful exclusion of competitors by unlawful means, the Court of Appeals validated a monopolistic business program.

The court below based its conclusion on two factors. First, the court found that the Prudent Buyer policy was an effort by a purchaser to achieve a low but not predatory price from its suppliers, an arrangement that "appear[ed]

6. The fundamental policy underlying the Sherman Act is to preserve competition as the national economic goal. *United States v. Philadelphia National Bank*, 374 U.S. 321, 372 (1963); *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 4 (1958); *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 495, n. 16 and cases cited therein (1940).

7. 15 U.S.C. § 2.

to bring low price benefits to the consumer." 883 F.2d at 1111. This was deemed to be a competitive course of conduct justified by valid business reasons and economic efficiency. *Id.* at 1112. Second, the court noted its reluctance to interfere in the domain of medical costs, "an area of great complexity where more than solely economic values are at stake." *Id.*, quoting *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922, 931 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). Then, as if by circular reasoning, the court determined that since Blue Cross' conduct was itself legitimate, the fact that the evidence indicated that the Prudent Buyer policy was *intended* to destroy or weaken Ocean State was "irrelevant." 883 F.2d at 1113.

The Court of Appeals' reasoning turns the method traditionally used to infer the intent element of monopolization on its head. Intent to monopolize is inferred from illegal acts, unfair business practices or conscious attempts to strengthen and maintain existing monopoly power. *United States v. Griffith*, 334 U.S. 100, 107-08 (1948); *United States v. United Shoe Mach. Corp.*, *supra*, at 342. It strains common sense to reason, as the Court of Appeals did, that a clearly expressed intent can be rebutted by "legitimate" conduct, particularly where that conduct maintains monopoly power. Indeed, explicit intent plus market dominance establishes the complete offense of monopoly. See *United States v. Grinnell Corp.*, *supra*, at 570-71.

The Court below expressly found that (1) Blue Cross was the *monopolist* in the Rhode Island market, and (2) the Prudent Buyer program was *willful*. 883 F.2d at 1110, 1113. Nonetheless, the Court of Appeals willingly sanctioned Blue Cross' actions as somehow distinguishable from otherwise illegal maintenance of its monopoly power. The court's particular predisposition to maintain this hands-off approach to the health care industry is all the more disturbing in light of the current health care crisis and the

articulated public policy favoring the growth of HMOs. Prudent Buyer was not the consequence of superior business acumen or healthy competition. Rather, it was a deliberate attempt at monopoly maintenance.⁹ Indeed, if Ocean State's rapid success is any indication, it, rather than Blue Cross, possessed the superior products and business acumen.

B. The Public Interest Will Be Harmed If The Court of Appeals' Decision is Left Undisturbed

Congress clearly expressed its intent that HMOs be made widely available as a health care alternative almost twenty years ago.¹⁰ In aid of this goal, Congress resolved that local exclusionary practices seeking to bar HMOs were *unlawful*. Section 300e-10(a) of the HMO Act provides that restrictive state laws and practices prohibiting entities

9. Judge Wyzanski's characterization of the leasing practices involved in *United States v. United Shoe Mach. Corp.*, *supra*, is equally applicable to the Prudent Buyer program:

[T]hey are not practices which can be properly described as the inevitable consequences of ability, natural forces, or law. They represent something more than the use of accessible resources, the process of invention and innovation, and the employment of those techniques of employment, financing, production, and distribution, which a competitive society must foster. They are contracts, arrangements, and policies which, instead of encouraging competition based on pure merit, further the dominance of a particular firm. In this sense, they are unnatural barriers; they unnecessarily exclude actual and potential competition; they restrict a free market.

Id. at 344-45.

10. § 300e-9 of the HMO Act, 42 U.S.C. § 300e-9(a), provides that employers must offer an HMO as one health benefits option to their employees.

from operating as HMOs shall not apply.¹¹ Thus, even without considering the proscription against abuse of monopoly power contained in the Sherman Act, there is a federal mandate for the establishment, protection and nurturing of HMOs.

Despite this clear policy, the Court of Appeals approved Blue Cross' conduct. When the court focused narrowly on the terms of the Prudent Buyer program and, at the same time, ignored its actual and *intended* effect, the court missed the true import of the Prudent Buyer Program, which was to make it as difficult as possible for an independent HMO to take root in Rhode Island. While the form of the program — seeking lower prices from physicians — arguably benefitted consumers in the short term, the long range consequences of Blue Cross' success will be

11. Section 300e-10(a), provides, in pertinent part:

In the case of any entity —

(1) which cannot do business as a health maintenance organization in a State to which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise —

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity,

[or]

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency. . . .

[s]uch requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization. . . .

to entrench its market monopoly by raising rivals' costs of competition. See Krattenmaker and Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 Yale L.J. 209 (1986). Yet, since the HMO traditionally offers more comprehensive coverage at lower rates, its financial success depends on the ability to pay physicians less than they are paid by Blue plans (whose premiums and copayment ratios are higher).

Once competition is stifled, premiums will again rise, health care coverage will become more difficult for many to afford and health care quality will suffer.¹² Exclusionary practices in other geographical markets will follow, with similar effects. More importantly, the alternatives offered by new, innovative entrants in the health care industry will be threatened as competition becomes more costly and the prospects of success appear less promising. This is of particular concern to U.S. Healthcare since, although the company enjoys a substantial market share in Pennsylvania and New Jersey, it is a relative newcomer to states such as Connecticut, Massachusetts and New Hampshire. U.S. Healthcare remains vulnerable to unfair monopolistic practices in these states and the states to which it may expand in the future.

This is not an illusory concern. U.S. Healthcare recently has become the target of one scheme that is blatantly unlawful, though the monopolist's conduct might be viewed as permissible should the Court of Appeals' decision stand. In New Hampshire, a competitor is attempting to

12. Monopoly power means that a monopolist may be freed from pressure to reduce costs, to develop new products, or to raise the quality of goods and services sold. 2 E.W. Kintner, *Federal Antitrust Law*, § 11.3 at 307 (1980) (hereafter "Kintner"). Judicial decisions involving Section Two of the Sherman Act have condemned in particular a monopolist's power to raise prices, restrict output, and lower the quality of goods and services. See, e.g., *United States v. Standard Oil Co.*, 221 U.S. 1 (1911); Kintner, *supra* at 307.

cement its grip on the market against incipient competition by adopting a program intended to prevent U.S. Healthcare from gaining a foothold in the market. Specifically, the competitor has "approved a substantial capitation rate increase to those primary care physicians *who will maintain exclusivity with us. . .*" In other words, the competitor, perhaps encouraged by the decision below, has implemented the plainly exclusionary policy of paying physicians more to stay away from competing plans. The net effect of the program will be to prevent incipient competition in the New Hampshire market with the resultant negative effects of a monopolistic or oligopolistic marketplace. The ultimate losers will be the employers who will pay higher premiums than necessary and the consumers who will not receive the choice and quality of care which fair competition would allow.

If this sort of practice can occur in one locale, it is likely to be successful in other places. Certainly, public policy and sound precedent underlying the antitrust laws should not condone this practice.

CONCLUSION

The decision of the Court of Appeals deviates from long-standing Sherman Act jurisprudence and ignores the Congressional intent underlying the HMO Act of 1973. In so doing, it insulates health care insurers from antitrust liability. There is no sound basis for treating the health care industry differently, particularly when monopolization is an important factor contributing to the nation's health care crisis. Accordingly, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the First Circuit.

Respectfully submitted,

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JOSEPH F. SPANIOL, JR.
CLERK

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

OCEAN STATE PHYSICIANS HEALTH PLAN, INC., *et al.*,
Petitioners,

v.

BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND,
Respondent.

On Petition for a Writ of Certiorari to the
United States Court of Appeals
for the First Circuit

**BRIEF OF AMERICAN MANAGED CARE
AND REVIEW ASSOCIATION AS AMICUS CURIAE
SUPPORTING PETITIONERS**

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TABLE OF CONTENTS

	Page
INTEREST OF THE AMICUS CURIAE	1
SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. This Case Offers This Court an Ideal Opportunity to Clarify How the More Consumer-Oriented, Less Protectionist Approach to Antitrust Law That It Has Taken Since the 1970s Applies to the Appraisal of Conduct of a Monopolist Under Section 2 of the Sherman Act and, Specifically, to Clear Up the Confusion Prevailing in the Lower Courts on the Important Subject of "Non-Price Predation"	5
II. The Rule of <i>Per Se</i> Legality Fashioned by the Court of Appeals for Any Practice Having a Colorable Business Justification Is an Unprecedented and Unjustified Overreaction to the Concern That Antitrust Suits Under Section 2 Will Deter Aggressive Competition by Large Firms..	8
III. The Court of Appeals Egregiously Misconstrued Blue Cross' Prudent Buyer Plan in Viewing It, as a Matter of Law, as a Cost-Reducing Measure That "Tends to Further Competition on the Merits"	13
IV. Monopolistic Practices by Insurers of the Particular Kind Involved in This Case Threaten Competition Not Only in the Market for Private Health Care Financing but, Even More Importantly, in the Market for Physicians' Services....	15
V. The Practices Immunized by the Court of Appeals in Applying the McCarran-Ferguson Act Are Potentially Destructive of Important Competition in Provider Markets as Well as in "the Business of Insurance." A Different Reading of the Act Would Provide Needed Protection Against Such Abuses	18
CONCLUSION	20

TABLE OF AUTHORITIES

CASES	Page
<i>A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.</i> , 881 F.2d 1396 (7th Cir. 1989), petition for cert. filed, No. 89-1075 (Dec. 29, 1989)	9
<i>American Medical Ass'n v. FTC</i> , 455 U.S. 676 (1982)	20
<i>Arizona v. Maricopa County Medical Soc'y</i> , 457 U.S. 332 (1982)	20
<i>Aspen Skiing Co. v. Aspen Highlands Skiing Corp.</i> , 472 U.S. 585 (1985)	6, 7, 12
<i>Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.</i> , 784 F.2d 1325 (7th Cir. 1986)	10, 13, 14, 15, 16
<i>Barry Wright Corp. v. ITT Grinnell Corp.</i> , 724 F.2d 227 (1st Cir. 1983).....	7, 9, 10, 11
<i>Berkey Photo, Inc. v. Eastman Kodak Co.</i> , 603 F.2d 263 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980)	6, 12
<i>Broadcast Music, Inc. v. CBS</i> , 441 U.S. 1 (1979)	5, 10
<i>Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.</i> , 429 U.S. 477 (1977)	6
<i>California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.</i> , 445 U.S. 97 (1980)	19
<i>Cargill, Inc. v. Monfort of Colo., Inc.</i> , 479 U.S. 104 (1986)	9, 10
<i>Continental T.V., Inc. v. GTE Sylvania Inc.</i> , 433 U.S. 36 (1977)	5
<i>FTC v. Indiana Fed'n of Dentists</i> , 476 U.S. 447 (1986)	20
<i>Group Life & Health Ins. Co. v. Royal Drug Co.</i> , 440 U.S. 205 (1979)	20
<i>Jefferson Parish Hosp. Dist. No. 2 v. Hyde</i> , 466 U.S. 1551 (1984)	20
<i>Kartell v. Blue Shield of Mass.</i> , 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985)	10, 11, 13, 14, 15, 16, 20
<i>Matsushita Elec. Indus. Co. v. Zenith Radio Corp.</i> , 475 U.S. 574 (1986)	9, 10, 11, 17
<i>Monsanto Co. v. Spray-Rite Service Corp.</i> , 465 U.S. 752 (1984)	9, 11

TABLE OF AUTHORITIES—Continued

	Page
<i>National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City</i> , 452 U.S. 378 (1981)	20
<i>Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.</i> , 472 U.S. 284 (1985)..	5, 10
<i>Patrick v. Burget</i> , 486 U.S. 94 (1988)	19, 20
<i>Royal Drug Co. v. Group Life & Health Ins. Co.</i> , 737 F.2d 1433 (5th Cir. 1984), cert. denied, 469 U.S. 1160 (1985)	10
<i>Telex Corp. v. IBM Corp.</i> , 510 F.2d 894 (10th Cir.), cert. dismissed, 423 U.S. 802 (1975)	6, 12
<i>Transamerica Computer Co. v. IBM Corp.</i> , 698 F.2d 1377 (9th Cir.), cert. denied, 464 U.S. 955 (1983)	10
<i>Travelers Ins. Co. v. Blue Cross of Western Pa.</i> , 481 F.2d 80 (3d Cir.), cert. denied, 414 U.S. 1093 (1973)	14, 16
<i>Union Labor Life Ins. Co. v. Pireno</i> , 458 U.S. 119 (1982)	20
<i>United States v. General Dynamics Corp.</i> , 415 U.S. 486 (1974)	5
<i>United States v. Griffith</i> , 334 U.S. 100 (1948)	6

STATUTES

McCarran-Ferguson Act:

15 U.S.C. §§ 1011 <i>et seq.</i>	4, 18, 19
--	-----------

Sherman Act:

15 U.S.C. § 1	5, 10
15 U.S.C. § 2	<i>passim</i>

MISCELLANEOUS

3 P. Areeda & D. Turner, <i>Antitrust Law</i> (1978)	11
Areeda & Turner, <i>Predatory Pricing and Related Practices Under the Sherman Act</i> , 88 Harv. L. Rev. 697 (1975)	9
R. Bork, <i>The Antitrust Paradox</i> (1978)	6, 7, 17

TABLE OF AUTHORITIES—Continued

	Page
Bureau of Competition, FTC, Staff Report on Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Pre- payment Plans (Apr. 1979)	16
<i>Challenges to the Chicago School Approach</i> , 58 Antitrust L.J. 627 (1989)	7
<i>Changes in Medicine Bring Pain to Healing Pro- fession</i> , New York Times, Feb. 18, 1990, at A1..	4
Havighurst, <i>The Questionable Cost-Containment Record of Commercial Health Insurers</i> , in Health Care in America (H. Frech ed. 1988)....	14
Hovenkamp, <i>Antitrust Policy After Chicago</i> , 84 Mich. L. Rev. 215 (1985)	7
Interstudy, <i>The Interstudy Edge</i> (Summer 1988)..	2
Kaplow, <i>Extension of Monopoly Power Through Leverage</i> , 85 Colum. L. Rev. 515 (1985)	7
Krattenmaker & Salop, <i>Analyzing Anticompetitive Exclusion</i> , 56 Antitrust L.J. 71 (1987)	7
Krattenmaker & Salop, <i>Anticompetitive Exclu- sion: Raising Rivals' Costs to Achieve Power over Price</i> , 96 Yale L.J. 209 (1986)	7, 14
<i>Many in Medicine Are Calling Rules a Profes- sional Malaise</i> , New York Times, Feb. 19, 1990, at A1	1
National Commission for the Review of Antitrust Laws and Procedures, <i>Report of the President and the Attorney General</i> (Jan. 22, 1979)	10
Posner, <i>The Next Step in the Antitrust Treatment of Restricted Distribution: Per Se Legality</i> , 48 U. Chi. L. Rev. 6 (1981)	8

**BRIEF OF AMERICAN MANAGED CARE
AND REVIEW ASSOCIATION AS AMICUS CURIAE
SUPPORTING PETITIONERS**

INTEREST OF THE AMICUS CURIAE

The American Managed Care and Review Association ("AMCRA") respectfully submits this brief amicus curiae in support of the pending petition for a writ of certiorari in this case in order that this Court may consider precisely how the decision below undercuts the utility of Section 2 of the Sherman Act, 15 U.S.C. § 2, as a protection for competition, not only in markets for health care-financing, but also in markets for health care services, particularly physician services.

1. AMCRA is a national trade association comprising over 500 health maintenance organizations ("HMOs"), preferred-provider organizations ("PPOs"), and other nontraditional mechanisms for financing and delivering medical care. Many AMCRA members are HMOs of the individual practice association ("IPA") variety, which depend for their competitive attractiveness on being able to offer access to a substantial number of community physicians, just as Blue Cross and Blue Shield plans typically do. The petitioner, Ocean State Physicians Health Plan, Inc. ("Ocean State"), is an IPA-type HMO and a member of AMCRA. Unlike Blue Cross and Blue Shield, IPA plans such as petitioner's place physicians at risk through the implementation of "physicians withholds" and other financial incentives.

2. HMOs have grown rapidly. "In 1970 there were 37 HMOs enrolling 3 million people. This January, there were 607 serving 32.5 million . . ." *Many in Medicine Are Calling Rules a Professional Malaise*, New York Times, Feb. 19, 1990, at A1, A13.¹ AMCRA and its members are concerned that the decision of the court of appeals in this case, if allowed to stand, would legalize a variety of practices on the part of dominant health

¹ IPA-type HMOs have been growing rapidly (J.A. 34).

insurers that will slow or even reverse the growth of competitive medical plans. In particular, a dominant insurer's practice of penalizing physicians for participating in an IPA-type HMO, in the way that Blue Cross and Blue Shield of Rhode Island ("Blue Cross") did in this case, can injure competition by eliminating the value of financial incentives, clearly threatening the existence of IPA-type HMOs.²

3. Because the parties litigated this case, and the lower courts decided it, with predominant regard to the effects of the challenged practices in the market for private health insurance and health care financing, the record, briefs, opinions, and the pending petition to this Court do not fully illuminate the significance of the case for the vigor of competition in another, even more important market—namely, the market for physician services. AMCRA is concerned that the court of appeals failed to appreciate how the respondent monopolist, in seeking to perpetuate and enhance its own market power, intentionally suppressed competition in this market. Because many AMCRA members were organized by physicians for the specific purpose of competing for patients in markets dominated by traditional health insurers like Blue Cross, AMCRA is in a good position to call the Court's attention to the destructive strategies employed by such insurers.

SUMMARY OF ARGUMENT

In holding that Blue Cross' Prudent Buyer program could not, as a matter of law, be deemed an exclusionary practice, the court of appeals invalidated the jury's contrary assessment of an admitted monopolist's conduct and rendered irrelevant all of the record evidence establishing (1) Blue Cross' predatory intent—specifi-

² While many HMOs are now quite large, none has a dominant market position in any market. The largest HMO is the Kaiser Foundation Health Plan. The largest IPA-type HMO is owned by U.S. Healthcare. Interstudy, *The Interstudy Edge* 28 (Summer 1988).

cially, its primary interest in raising the costs of its competitor, Ocean State; (2) the actual exclusionary nature of Blue Cross' practice—despite its ostensible business purpose; and (3) the actual, direct effects of the practice on Ocean State's competitiveness, on the price of health insurance, and on consumer welfare. The court's ruling amounted to the creation of an unprecedented rule of *per se* legality for any exclusionary practice for which a defendant monopolist offers a colorable business rationale. This holding is directly at odds with accepted understanding of Section 2 of the Sherman Act.

The court of appeals apparently adopted its rule of *per se* legality in an attempt to accommodate the significant shift that has occurred in antitrust economic thinking in the last two decades. This new thinking, which this Court has ratified to some extent, has generally featured greater skepticism toward private treble-damage suits, greater receptivity to efficiency-based defenses, and special vigilance to prevent competitors from using Section 2 to deter hard competition by large firms. Despite the virtues of this new economic thinking, however, the conduct of the monopolist challenged in this case should not have been given the extraordinary protection implicit in a rule of *per se* legality, a standard which this Court has never endorsed.

The court of appeals made fundamental errors of factual and economic analysis in interpreting the Prudent Buyer program as a normal business' attempt to lower its input costs. However, a comparison with the business practices of other health insurers, which are well documented in other cases, shows that Blue Cross did not in fact seek to buy physicians' services at the most favorable (or even at competitive) prices. In dealing with Ocean State physicians, its primary object was to induce them to accept the higher price, not the lower one. By paying physicians generously and *not* using its potential buying power aggressively against them (until some of them stepped out of line by marketing through Ocean State), it hoped to remain their sole marketing

agent, with all the monopoly power attendant on that position. The lower court's failure to recognize the nature of Blue Cross' monopoly and the consequences of its conduct demonstrates the danger of a legal rule under which any appearance of a business justification forecloses further inquiry into the purpose and effect of a monopolist's behavior.

The other Blue Cross practices challenged by Ocean State—those that the court of appeals deemed immunized by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011 *et seq.*,—are likewise easily employed by dominant health insurers to maintain market control by excluding HMOs and other competitive medical plans. AMCRA therefore urges this Court to rule that the McCarran exemption, which was enacted well before the implied exemption for "state action" became crystallized, embodies the same requirement of "active state supervision" of exempt private conduct that the Court now imposes as a prerequisite for state-action immunity.

Ocean State's petition should be granted not only because this case raises serious issues of antitrust doctrine but also because the challenged practices have grave implications for the state of competition in the enormous health care industry which currently represents approximately 11% of this country's Gross National Product. *Changes in Medicine Bring Pain to Healing Profession*, New York Times, Feb. 18, 1990, at A1. In particular, the development of competitive health plans, particularly HMOs of the IPA variety, is jeopardized by the practices of which Ocean State complains. Non-traditional mechanisms for financing and delivering health care are essential vehicles for introducing effective price (as well as quality) competition into local markets for providers' services, where such competition has long been lacking because of the traditional practices of conventional health insurers. This case presents a classic instance of a nonprofit health insurer that, in pursuing its own monopolistic objectives, has suppressed competition in the market for physician services.

ARGUMENT

I. This Case Offers This Court an Ideal Opportunity to Clarify How the More Consumer-Oriented, Less Protectionist Approach to Antitrust Law That It Has Taken Since the 1970s Applies to the Appraisal of Conduct of a Monopolist Under Section 2 of the Sherman Act and, Specifically, to Clear Up the Confusion Prevailing in the Lower Courts on the Important Subject of "Non-Price Predation"

Since the mid-1970s, this Court has significantly refined its analysis in antitrust cases to take a more pragmatic approach in the search for adverse effects on competition. For example, in *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974), the Court moved away from evaluating horizontal mergers almost exclusively on the basis of market shares, inviting a more searching analysis that focuses on the actual competitive consequences. Similarly, in *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36 (1977), the Court overruled its previous *per se* approach to non-price vertical restraints, recognizing that restrictions on the number and competitive independence of a manufacturer's distributors can sometimes strengthen competition between manufacturers, benefitting consumers. More recently, in appraising competitor collaboration under Section 1 of the Sherman Act, 15 U.S.C. § 1, the Court has demonstrated a new willingness to recognize that such collaboration may often promote efficiency more than it harms competition, thereby increasing consumer welfare. *E.g., Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284 (1985); *Broadcast Music, Inc. v. CBS*, 441 U.S. 1 (1979).

Despite the strides that this Court has made in helping lower courts assess business combinations and concerted action for consistency with the statutory mandate to preserve competition in the interest of consumers, it has yet to provide comparable guidance for appraising the conduct of dominant firms under Section 2 of the Sherman Act. Indeed, it has decided only one case under

Section 2 in the last 16 years, *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985). Because of its unusual facts that case did not effectively clarify the significance for Section 2 analysis of the new antitrust thinking, under which, conduct, that is truly efficiency-enhancing, may be valued for its own sake even if a competitor's survival may be jeopardized.

In the absence of clear guidance from this Court, some lower courts, taking their cue from this Court's generally greater skepticism toward private antitrust actions, have allowed large, even dominant, firms somewhat greater leeway to respond to competition than older Supreme Court precedents seemed to contemplate.³ Although many of these lower court rulings appear to give correct effect to the Court's view that antitrust law is intended to protect "competition, not competitors,"⁴ the Ocean State decision in the court of appeals demonstrates that there is a danger that the pendulum may swing too far, depriving Section 2 of its vitality as a defense against practices that on close inspection can be shown to be predatory or exclusionary.⁵

³ See, e.g., R. Bork, *The Antitrust Paradox* 136-60, 299-309, 344-46 (1978); compare *United States v. Griffith*, 334 U.S. 100, 107 (1948) (dictum implying that doing business as a monopolist or using monopoly to gain a competitive advantage is unlawful without regard to how power was obtained) with *Telex Corp. v. IBM Corp.*, 510 F.2d 894, 926 (10th Cir.), cert. dismissed, 423 U.S. 802 (1975) (putative monopolist allowed to use "ordinary marketing methods available to all in the market") and *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 276 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980) (monopolist entitled to enjoy, in competitive markets, benefits flowing from vertical integration with its monopoly).

⁴ *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977).

⁵ Indeed, the so-called "Chicago School" of economic analysis, in reacting against the era when some procompetitive conduct may have been penalized too quickly, may have encouraged the courts to go to the opposite extreme of tolerating—even legalizing per se conduct that in some circumstances can create or perpetuate a

The extensive literature on predatory pricing has helped the lower courts to develop the law in that area with considerable sophistication.⁶ More recently, however, scholars have begun to refine the notion of strategic behavior by a monopolist, particularly the phenomenon increasingly known as "non-price predation."⁷

Unfortunately, case law in the lower courts has not revealed a sophisticated grasp of the issues involved in non-price predation. See Krattenmaker & Salop, *Analyzing Anticompetitive Exclusion*, 56 Antitrust L.J. 71, 89-90 (1987) (noting that "substantial disarray" in laws governing exclusionary conduct reflects conflict between prevailing doctrine and "pleas for laissez-faire" rules of per se legality). Unlike predatory pricing, non-price predation can take many forms and easily eludes efforts to develop objective, cost-based tests. The instant case provides an opportunity for this Court to supply up-to-date economically based principles for applying Section 2 to non-price predation.

monopoly unjustified by efficiency and harmful to consumers' interests. See *Challenges to the Chicago School Approach*, 58 Antitrust L.J. 627 (1989). Recent scholarship develops just this thesis in a variety of areas of antitrust law but most particularly in the area of exclusionary conduct. E.g., Hovenkamp, *Antitrust Policy After Chicago*, 84 Mich. L. Rev. 215, 255-83 (1985) (discussing "strategic behavior," including "raising rivals' costs"); Kaplow, *Extension of Monopoly Power Through Leverage*, 85 Colum. L. Rev. 515 (1985).

⁶ See, e.g., *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227 (1st Cir. 1983), and cases and articles cited therein.

⁷ The leading article developing this new theme is Krattenmaker & Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 Yale L.J. 209 (1986). This Court has so far provided only limited guidance on this important subject. In *Aspen Skiing*, the Court defined the issue as whether the monopolist had tried to exclude a rival "on some basis other than efficiency." 472 U.S. at 605, quoting R. Bork, *supra*, at 138. But, because the defendants offered no business justification whatsoever, the Court gave no guidance to the lower court on how efficiency claims were to be weighed against evidence of exclusionary purpose and effect. The instant case presents just this issue.

II. The Rule of *Per Se* Legality Fashioned by the Court of Appeals for Any Practice Having a Colorable Business Justification Is an Unprecedented and Unjustified Overreaction to the Concern That Antitrust Suits Under Section 2 Will Deter Aggressive Competition by Large Firms

Despite the jury's apparent conclusion that Blue Cross' Prudent Buyer program constituted exclusionary conduct, the court of appeals held, as a matter of law, that it could not be so categorized. The court reasoned that "insisting on a supplier's lowest price . . . tends to further competition on the merits and, as a matter of law, is not exclusionary." Pet. App. 19a.

There is no basis in the precedents of this Court or elsewhere, however, for holding that any conduct that facially "tends to further competition on the merits" is lawful *per se*—thus rendering nugatory all other evidence. If the court of appeals is to be believed, summary judgment for a monopolist would be appropriate even though the plaintiff could demonstrate that a seemingly innocuous practice did not in fact "further competition on the merits" but instead gratuitously raised rivals' costs and increased the monopolist's market power. Surely this is not the law.

Some have argued that certain vertical restraints of trade should be declared lawful *per se*.⁸ Such arguments are also based on the now-familiar fear that the threat of nonmeritorious antitrust suits will inhibit desirable competitive behavior—specifically, a manufacturer's efforts to market its products efficiently, or in combination with desired services, in competition with other sellers. However, this Court has protected against the stifling of efficient marketing strategies, not by ruling that certain practices are *per se* legal, but by raising plaintiffs' burden of proving that there was an actual vertical agree-

⁸ E.g., Posner, *The Next Step in the Antitrust Treatment of Restricted Distribution: Per Se Legality*, 48 U. Chi. L. Rev. 6 (1981).

ment to fix resale prices. Thus, the Court held in *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 763-64 (1984), that, in order to prevent "highly ambiguous evidence" from being misconstrued by the finder of fact, the plaintiff must tender evidence that "tends to exclude the possibility that the manufacturer and nonterminated distributors were acting independently." In *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 588 (1986), the same evidentiary requirement was imposed in granting summary judgment against plaintiffs alleging an improbable horizontal conspiracy to practice predatory pricing.

Admittedly, there is some lower court authority for a special rule of per se legality under Section 2 for certain prices that plaintiffs might allege to be predatory. Thus, certain prominent scholars have argued that, whatever the evidence of intent and effect on competition, a claim of predatory pricing should not be submitted to the jury if the putative predator did not set prices that were "below some appropriate measure of cost." *Matsushita*, 475 U.S. at 584-85 nn.8, 9, citing Areeda & Turner, *Predatory Pricing and Related Practices Under the Sherman Act*, 88 Harv. L. Rev. 697 (1975). Indeed, the leading judicial authority for the per se legality of prices above both "incremental cost" and "average total cost" is Judge Breyer's opinion for the First Circuit in *Barry Wright Corp. v. ITT Grinnell Corp.*, 724 F.2d 227, 233-35 (1st Cir. 1983). See also *A.A. Poultry Farms, Inc. v. Rose Acre Farms, Inc.*, 881 F.2d 1396 (7th Cir. 1989), *petition for cert. filed*, No. 89-1075 (Dec. 29, 1989).

The arguable justification for conclusively presuming legality in certain predatory pricing cases is that, despite the rarity of true predatory pricing, *Matsushita*, 475 U.S. at 588, there is still a great temptation for competitors facing stiff price competition from efficient large firms to file antitrust suits portraying themselves as victims of such price predation. *Cargill, Inc. v. Monfort of Colo., Inc.*, 479 U.S. 104, 121 n.17 (1986). Without a basis for dismissing these cases at an early stage, there

is always a risk that juries will find violations based on equivocal evidence of intent. *Barry Wright*, 724 F.2d at 232, 235. Even so, however, the proposal to adopt such a rule of per se legality has engendered great controversy,⁹ and some lower courts have refused to embrace the idea.¹⁰ This Court has never specifically addressed the issue. *Cargill*, 479 U.S. at 117 n.12.

In any event, assuming, arguendo, that there are considerations that might warrant a rule of per se legality in certain predatory pricing cases, no similar considerations are present in the circumstances of this case.¹¹ The physician petitioners are not complaining about being forced to accept low prices or to compete for patients on the basis of price. On the contrary, their complaint is that Blue Cross penalized them for competing—by marketing their services at a discount outside the Blue Cross system. By the same token, Ocean State itself was not an

⁹ See, e.g., National Commission for the Review of Antitrust Laws and Procedures, *Report of the President and the Attorney General* 149-51 (Jan. 22, 1979).

¹⁰ See, e.g., *Transamerica Computer Co. v. IBM Corp.*, 698 F.2d 1377, 1386-88 (9th Cir.), cert. denied, 464 U.S. 955 (1983) (rejecting per se legality of prices above average total costs), and cases there cited. Nor has this Court itself ever indicated that a rule of per se legality is a proper response to the danger that price competition might be inhibited. See *Matsushita*, 475 U.S. at 585 n.9. Indeed, its hesitancy in applying and extending rules of per se illegality in recent cases under Section 1 suggests that per se rules of all kinds are to be approached with great caution. See, e.g., *Northwest Wholesale Stationers; Broadcast Music*, 441 U.S. at 19-24.

¹¹ Although health care providers have brought many antitrust suits to contest hard bargaining by large purchasers, the courts have consistently rejected them. E.g., *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986); *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985); *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984), cert. denied, 469 U.S. 1160 (1985). Such suits have therefore become less common, demonstrating that large buyers do not need any special protection against erroneous outcomes or the high cost of litigation challenging their aggressive purchasing.

inefficient competitor seeking the court's protection against hard competition by an efficient rival. Indeed, it was Ocean State which initiated the discounts that Blue Cross now wants to eliminate through the exercise of its market power. Clearly, the Blue Cross plan in this case is decidedly not one of those health insurers that pursues aggressive cost containment in the interest of consumers.¹²

Following its approach in *Monsanto* and *Matsushita*, this Court might rule in this case that the lower courts should protect conduct that is potentially beneficial to consumers, not by adopting rules of *per se* legality, but by requiring plaintiffs to produce evidence that "tends to exclude the possibility" that the practices challenged were procompetitive, efficiency-enhancing, or otherwise non-predatory business behavior consistent with "competition on the merits."¹³ Such a ruling would discourage antitrust suits by competitors merely seeking protection against hard competition, thus preserving the vigorous competition that modern antitrust law seeks to foster on consumers' behalf. But unlike the court of appeals' holding in this case, it would not leave Section 2 of the Sherman Act a dead letter against any exclusionary conduct that facially resembles ordinary business activity.¹⁴

¹² It is ironic that the same court of appeals that handed down the leading cases (1) defending large firms against competitors' misplaced charges of predatory pricing (*Barry Wright*) and (2) protecting large health insurers against physicians' misplaced charges of monopsonistic purchasing (*Kartell*) should have failed so conspicuously in applying those cases' underlying principles in this case. It should be noted that Judge Breyer, the former law professor who authored the opinions in both *Barry Wright* and *Kartell*, was not on the panel in *Ocean State*.

¹³ The following widely cited definition of exclusionary conduct suggests such a heavy burden of proof: "behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way." 3 P. Areeda & D. Turner, *Antitrust Law* ¶ 626b at 78 (1978).

¹⁴ Because the petitioners in this case offered a great deal of evidence showing the anticompetitive purpose and effect of Blue Cross'

The errors of the court of appeals in this case are perhaps understandable in light of some of the leading court of appeals decisions under Section 2 in recent years. These decisions have heavily emphasized the importance of allowing even undoubted monopolists to follow normal business practices.¹⁵ Although it is certainly important to avoid judicial "handicapping" in an artificial effort to equalize the competitive race, a defendant monopolist should not be entitled to win merely by demonstrating that its action had a "rational basis." The rule-of-reason test of *Aspen Skiing* surely requires stricter scrutiny than that—i.e., more than a search for some rationale for the challenged conduct that is both facially plausible and permissible.¹⁶ Yet, without clearer guidance from this Court, lower courts may simply accept, as the court of appeals did in this case, any facially plausible explanation for a monopolist's strategic maneuvers, even though those practices could be seen under "close scrutiny" to have been intended to raise rivals' costs and to perpetuate the monopolist's freedom to charge supracompetitive prices.¹⁷ Again, the correct way to ensure that competition is not jeopardized unnecessarily, either by inhibiting antitrust rules or by monopolistic practices, is to make plaintiffs demonstrate affirmatively—as *Ocean State* did—that competition and consumer welfare were harmed, not helped, by the practices in question.

Prudent Buyer program, they were entitled to the benefit of the jury's verdict.

¹⁵ E.g., *Telex and Berkey Photo*, described *supra* note 3.

¹⁶ See *supra* note 7.

¹⁷ The defendant in *Aspen Skiing* lost because it "did not persuade the jury that its conduct was justified by any normal business purpose." 472 U.S. at 608. In this case, Blue Cross similarly failed to convince the jury, yet won because the court of appeals was unwilling to let the jury decide the issue. Actually, however, the skiing monopolist's object of preventing a free-riding competitor from sharing the rewards from its lawful monopoly (which, after all, attracted skiers to Aspen) was a more "normal business purpose" than Blue Cross' object of inducing physicians to deal exclusively with it and to boycott *Ocean State*.

III. The Court of Appeals Egregiously Misconstrued Blue Cross' Prudent Buyer Plan in Viewing It, as a Matter of Law, as a Cost-Reducing Measure That "Tends to Further Competition on the Merits"

In characterizing the Prudent Buyer plan as nothing more than "insisting on a supplier's lowest price," the court of appeals chose to see Blue Cross' effort only as a cost-reduction strategy. The court of appeals was wrong on three counts—first, in believing that Blue Cross was truly and primarily interested in reducing its costs; second, in believing that Blue Cross' method was calculated to "get the lowest possible price" or "the best deal possible" (Pet. App. 19a-23a); and third, in believing that allowing the practice would "bring low price benefits to the consumer" (*id.* at 21a). Far from justifying the court's view of the case, the evidence in the record easily supports the jury's apparent conclusion that the program was part of a scheme to pay physicians, not less, but more—as long as they did not sell their services at a discount to Ocean State. This strategy was specifically intended to perpetuate Blue Cross' position as the physicians' exclusive marketing agent, to raise Ocean State's costs, and to enhance Blue Cross' power over price. The record shows that consumers paid higher prices, not lower, as a consequence of Ocean State's reduced ability to check Blue Cross' premium increases.¹⁸

That Blue Cross was not interested in getting "the best deal possible" from physicians is easily demonstrated by comparing what it did with the actions of comparable insurers in the *Kartell* and *Ball Memorial* cases, *supra* note 11. In those cases, the courts (in opinions by Judges Breyer and Easterbrook, respectively) upheld health insurers' aggressive cost reduction efforts against antitrust challenges lodged by the affected providers. Those insurers, in demanding that providers accept the plan's allowances as payment in full (*Kartell*) or that they offer their best price in competitive bidding (*Ball Memorial*),

¹⁸ J.A. 1110-13, 1847-49, 2183-84.

were plainly engaged in efforts to "get the best deal possible" for their subscribers. Despite the view of the court of appeals that the result in *Ocean State* was "compelled" by its earlier holding in *Kartell*, the Rhode Island plan followed a policy fundamentally different from the aggressive cost containment seen in both *Kartell* and *Ball Memorial*.

Thus, Blue Cross allowed "balance billing" by non-participating physicians and sought lower fees only from those physicians that persisted in dealing with Ocean State—hardly the way to "get the best deal possible" from physicians. Thus, instead of concluding that Blue Cross was seeking only to pay lower prices, the court should have said that Blue Cross was offering to pay *more* to each physician who eschewed marketing at a discount through other outlets.¹⁹ Despite its euphemistic name, the Prudent Buyer program was not calculated to obtain low physician fees in general, but only to penal-

¹⁹ Ironically, the first case to approve efforts by a Blue Cross or Blue Shield plan to "get the best deal possible"—indeed, the case from which the *Kartell* and *Ocean State* courts quoted that phrase—also misconstrued the plan's actions and excused what was in fact a monopolistic rather than simply a cost-containment strategy. *Travelers Ins. Co. v. Blue Cross of Western Pa.*, 481 F.2d 80, 84 (3d Cir.), cert. denied, 414 U.S. 1093 (1973). The discounts from regular hospital charges enjoyed by the Blue Cross plan in that case were not the result of hard bargaining with competing hospitals. Instead, "the hospitals negotiated *jointly*" with Blue Cross (*id.*)—that is, as a cartel. By accepting from the hospital association a smaller discount than it could have gotten by forcing the hospitals to compete, the insurer monopolist kept the cartel intact as an obstacle to its would-be competitors, raising their costs. See Krattenmaker & Salop, *supra*, 96 Yale L.J. at 238-40 (maintenance of supplier cartel as an exclusionary practice). Although paying hospitals more than if it had used its purchasing power to destroy their cartel, Blue Cross enjoyed a greater net cost advantage over its competitors than it would have had if hospitals competed for the business of all payers. For a fuller explanation of this monopolist's unrecognized strategy, see Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in *Health Care in America* 221, 250-53 (H. Frech ed. 1988).

ize Ocean State doctors.²⁰ Indeed, the record shows rather strikingly that Blue Cross' mind was more on raising Ocean State's costs than on lowering its own.²¹

A possible interpretation of Blue Cross' action, seemingly adopted by the court of appeals, is that it was simply targeting those doctors who had already signified their willingness to accept lower fees—in other words, that it was merely defending itself against price discrimination being practiced against it by its suppliers. But the notion that a buyer with an 80% market share was a *victim* of price discrimination is patently absurd. Far from demonstrating that Blue Cross was seeking to "get the best deal possible," this circumstance reveals that Blue Cross had assiduously *refrained* from exercising its buying power against physicians and that it was Ocean State that finally brought competition to the market for physician services in Rhode Island. Of course, if Blue Cross had used its buying power to the fullest in the consumer's interest instead of using it selectively to obtain an unnatural market advantage, there would have been no basis for Ocean State to complain. But it is Blue Cross that is price-discriminating—in what it pays physicians—obviously hoping by such discrimination to discourage doctors from embarking on the competitive path of discounting their services and selling through alternative outlets.

IV. Monopolistic Practices by Insurers of the Particular Kind Involved in This Case Threaten Competition Not Only in the Market for Private Health Care Financing but, Even More Importantly, in the Market for Physicians' Services

Nonprofit health insurance offered under the Blue Cross and Blue Shield trademarks has a long and venerated history in the United States. As the market for

²⁰ "Prudent purchasing" is a term of art in the health care industry signifying aggressive purchasing of precisely the kinds found in *Kartell* and *Ball Memorial*.

²¹ J.A. 336-39, 850-55, 1208-09, 1220-22, 1227-31; P.E. 45, 294, 344.

health insurance has evolved in different places, however, two essential types of "Blue" plans have emerged—one selling services on behalf of providers and the other purchasing services on behalf of its subscribers. Although nearly all Blue plans began life as monopolistic joint selling agencies controlled by the providers whose services they sold,²² provider control gradually eroded. Some plans evolved into ordinary insurers, purchasing services as consumers' agents. But others, particularly those with very large market shares, found that their corporate interests were still served best by remaining the ally of providers rather than by becoming aggressive purchasers of their services. The respondent in this action is a prime example of a plan whose monopoly made this a feasible strategy—as was the Blue Cross plan in the 1973 *Travelers* case, discussed *supra* note 19. The plans in *Kartell* and *Ball Memorial* are examples of plans with a different orientation. See Pet. 19 (on Indiana Blue Cross' switch to the consumer's side).

In expressly characterizing the Rhode Island plan as one that "purchases health services . . . on behalf of its subscribers," Pet. App. 2a, the *Ocean State* court signified its failure to focus on the crucial distinction between that plan and the plans in *Ball Memorial* and *Kartell*. In that distinction lies one of the keys to this case. The Blue Cross monopolist, hoping to enjoy the benefits of its dominant market position, undertook to induce exclusive dealing by strategic pricing, charging more to employers who offered the *Ocean State* option and paying less to physicians who marketed through an alternative plan. These strategies were aimed at stamping out alternative health plans and raising the costs of any that survived. Under the Blue Cross monopoly, there would be virtually no opportunity for a physician to engage in price competition—that is, to increase patient volume by lowering price. Thus, Blue Cross suppressed

²² See Bureau of Competition, FTC, Staff Report on Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans (Apr. 1979) (unpublished).

the competition from which consumers had the most to gain (and Blue Cross had the most to lose).

The ultimate reason why the court of appeals could see little potential harm to consumers in what Blue Cross did to Ocean State is that it overlooked entirely the possibility that a dominant nonprofit health insurer might have monopolistic reasons of its own for *not* seeking to "get the best deal possible"²³ and for instead allying itself explicitly or implicitly with providers and suppressing competition among them.²⁴ In fact, however, a nonprofit, regulated health insurer has little reason not to overpay providers if it can thereby prevent the emergence of alternative outlets through which they can sell their serv-

²³ The practice of paying physicians supracompetitive fees in order to raise rivals' costs could easily qualify for condemnation as a predatory practice under the rationale routinely used in condemning predatory pricing. Significant current outlays aimed, not at increased efficiency, but only at gaining or keeping a monopoly are appropriate targets for policing under Section 2. *See* R. Bork, *supra*, at 137-48.

²⁴ The theory that Blue Cross sought to monopolize by specifically refraining from efforts to "get the best deal possible"—from everyone, that is, except Ocean State physicians—must be examined to see whether it makes "economic sense." *Matsushita*, 475 U.S. at 598 (approving grant of sumary judgment against plaintiffs on the ground that complaint, which contemplated a decades-long, improbable conspiracy to practice predatory pricing, "simply [made] no economic sense"). After all, it might be argued, a rational Blue Cross monopolist would not choose to incur unnecessarily high costs in the short run if it could not realistically hope to recover them in the long run—either because the firm is subject to price regulation or because its nonprofit character precludes anyone's direct enjoyment of future monopoly profits. But a business strategy of serving provider rather than consumer interests would appeal to a nonprofit, regulated insurer precisely because it is regulated and has no significant interest in profits as such. Such a firm can enjoy the nonpecuniary benefits that flow from monopolizing the marketing of physician services—e.g., large size and cash flow, with the attendant prestige, perquisites, and job security for corporate managers—while regulation, which regards the costs incurred for physician services simply as an expense to be passed on to consumers, allows the physicians to enjoy the monetary rewards.

ices. Only if this Court corrects the errors made by the court of appeals in this case can Section 2 be used to prevent similar abuses in other health care markets.

V. The Practices Immunized by the Court of Appeals in Applying the McCarran-Ferguson Act Are Potentially Destructive of Important Competition in Provider Markets as Well as in "the Business of Insurance." A Different Reading of the Act Would Provide Needed Protection Against Such Abuses

Although this Court reasonably might elect in this case to review only those issues related to Blue Cross' Prudent Buyer program, the issues raised under the McCarran-Ferguson Act are of equal practical significance. Indeed, actions of the kind treated by the court of appeals as immune from antitrust attack under the McCarran Act also have the potential for destroying the market opportunities of HMOs and other innovative health plans and for foreclosing competition among providers. If dominant health insurers are able to practice differential pricing, ostensibly to offset the effects of adverse selection, without meaningful regulatory oversight, emerging HMOs and other competitive medical plans will be easy targets for predatory pricing. Moreover, regulated nonprofit insurers like Blue Cross have less of a disincentive to engage in predatory pricing than other would-be monopolists because they have reserves that can be used to defray current losses and that can be replaced through higher rates once the threat is past. In addition, they operate over geographic areas larger than most HMOs, yet can target their price cuts and sail their "fighting ship" HMOs wherever competition threatens to get a foothold. They may also be able to reduce their payments to providers (an apparently procompetitive move) as a way of financing a predatory campaign, a practice that many providers may approve as a way of staving off competition that they too wish to avoid. Even if regulators are alert, they may be hard-pressed to prevent pricing strategies that are exclusionary in fact. If the regulators fail, as in this case, even

to consider the specific practices that carry the risk of abuse, antitrust immunity is an invitation to suppress the most promising forms of price competition in the health care industry.

Certainly the insurance regulatory scheme in this case left Blue Cross the opportunity to engage in predation with impunity. As petitioners argue, this Court should consider the significance of the fact that the state's oversight in this case was clearly insufficient to constitute "active state supervision" under the two-part test for "state-action" immunity laid down in *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). See also *Patrick v. Burget*, 486 U.S. 94 (1988).

There is some authority for the view that the McCarran exemption, being explicit, is broader than the comity-inspired implied exemption for state action. However, the McCarran Act was passed well before the courts, construing the Sherman Act not to preempt the states as economic policy makers, finally defined what a state must do before federal antitrust policy will give way. This Court should take this occasion to consider the argument that the McCarran Act, in requiring state regulation as a condition of exemption, was simply a precursor of the state-action doctrine and did not provide any more sweeping immunity than that which this Court subsequently inferred from the Sherman Act itself. It seems unlikely, for example, that Congress, in the same statute that expressly barred state insurance regulators from authorizing predatory "boycott[s], coercion or intimidation," intended to free private insurers to set possibly predatory prices without actual state supervision. As petitioners observe, this case provides an ideal vehicle for addressing this extremely important issue. As petitioners also argue, even if the McCarran defense is valid for two of the three tactics Blue Cross employed against Ocean State, this Court should still indicate that evidence concerning the nature and mono-

polistic tendency of those actions is relevant in interpreting the nonexempt conduct.

CONCLUSION

The court of appeals rested its decision in this case in part on its "reluctan[ce] to interfere in the domain of medical costs, 'an area of great complexity.'" Pet. App. 21a, quoting *Kartell v. Blue Shield of Mass.*, 749 F.2d 922, 931 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985). AMCRA respectfully submits that the health care industry is a crucially important sector of the economy in which to ensure that competition is operating and that its "complexity" provides no justification for adopting legal rules that obscure market reality. Fortunately, this Court has itself not been reluctant to address difficult antitrust issues arising in the health care and health insurance industries in recent years.²⁵ Unfortunately, the Court must visit the field once again.

Respectfully submitted,

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²⁵ *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378 (1981); *American Medical Ass'n v. FTC*, 455 U.S. 676 (1982) (per curiam) (affirmed by an equally divided court); *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 1551 (1984); *Patrick v. Burget*; *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 477 (1986).

